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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

ON

EXAMINING THE IMPLEMENTATION OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (PUBLIC LAW 104–191), FOCUSING ON THE FEDERAL AND STATE REGULATORY PROCESS OF IMPLEMENTING INSURANCE REFORM PROVISIONS

FEBRUARY 11, 1997

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TUESDAY, FEBRUARY 11, 1997

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:45 a.m., in room SD–430, Dirksen Senate Office Building, Senator Jeffords (chairman of the committee) presiding.

Present: Senators Jeffords, Enzi, Collins, Warner, Kennedy, Mikulski, Bingaman, Wellstone, Murray, and Reed.

OPENING STATEMENT OF SENATOR JEFFORDS

The CHAIRMAN. Good morning.

Today's oversight hearing is being held on the Health Insurance Portability and Accountability Act of 1996, also known as the Kassebaum-Kennedy bill. This landmark legislation provides national standards relating to health insurance coverage by guaranteeing the availability and portability of private health insurance coverage for certain groups and restricting the use of preexisting condition restrictions.

This hearing is being held in order to provide the committee with up-to-date information on the actions taking place at both the Federal and the State levels relating to the implementation of the insurance reform provisions of the Kassebaum-Kennedy bill.

This information will allow the committee to assist in ensuring a smooth and successful implementation of this legislation that is consistent with the legislative intent.

All panelists have been asked to comment on the progress that has been made in carrying out their respective responsibilities, as well as to recommend steps that Congress can take to help in resolving any problem areas that exist.

The hearing will consist of three panels—representatives of Federal agencies, witnesses to address State implementation, and witnesses to address employers' compliance and consumer concerns.

The first panel will focus on the status of Federal rule making. The witnesses from three Federal agencies have been asked to comment on the actual process of promulgating the regulations, the extent to which the various departments have worked together—including the development of a memorandum of understanding—and the extent to which they involved the States and the private sector in promulgating the regulations.

The second panel will discuss issues related to State implementation of group health insurance to individual health insurance portability requirements.

Finally, the third panel will present information on how the business community, as well as consumers, are preparing to comply with the new requirements of HIPAA.

Before proceeding, I will turn to the ranking member and my good friend, Senator Kennedy.

Opening Statement of Senator Kennedy

Senator KENNEDY. Thank you very much, Mr. Chairman, for holding this very timely hearing today on the implementation of last year's health reform legislation, and I thank our witnesses who are working hard to carry out the legislation and see that the Act is implemented efficiently and fairly. I have been impressed with how effectively the three agencies have worked together and how open and receptive they have been to accommodating the legitimate concerns of affected groups.

Passage of the Kassebaum-Kennedy legislation was an important first step in addressing serious health insurance abuses and providing greater protection to millions of families. Our bipartisan action lat year broke the gridlock over health reform and put us back on track toward addressing the many problems in the current health care system.

Today's hearing is timely because of the need to deal with a misconception about the Federal legislation. Some are trying to use that legislation to weaken existing State insurance reform efforts or to encourage States to comply in only the minimal way.

The intent of the Federal legislation was clearly to establish a Federal floor, not a Federal ceiling. States are free to go further and should go further, especially in areas that provide greater consumer protection. Nothing in last year's actions preempts additional safeguards by the States.

A second issue that will be raised in today's testimony is the ability of insurance companies and health plans to certify coverage. Employers and insurance companies will need to make a concerted effort to comply with this provision within the time frame allotted in the bill.

One concern that has been raised is whether the timetable is too tight. All of the groups testifying today were actively involved in the development of the bill. The legislation was introduced in July 1995. The language and intent of both the House and Senate bills have always been clear, without the need for further regulations. The bill was signed into law last August, and 45 States already have portability requirements in the small group market. There has been adequate time to prepare for this certification.

In addition, a good faith clause in the legislation protects employees and insurance companies. The administration has consistently shown its willingness to work with others to make this provision as simple as possible.

Finally, there are concerns that, due to short legislative sessions, it may be difficult for some States to develop an alternative program to the Federal group to individual portability requirements in the bill. I appreciate the fact that the timetable is tight, but Con-

gress intended for it to be tight because the American people have been deprived of this protection for too long.

I understand the administration intends to be as flexible as possible in giving States an opportunity to develop alternative mechanisms, and I appreciate these efforts. Everyone should be aware that any State that does not meet the timetable is able to develop such mechanisms at any time. The only consequence of failure to notify the Secretary of an alternative mechanism by this April is that the Federal standards will go into effect until such time as the State does develop an alternative mechanism.

So there is little justification to postpone any of the implementation dates in the legislation, especially for the certification requirement, which is the key to the portability protections.

The American people are depending upon us to see that these protections are implemented expeditiously. We know that too many people are falling through the cracks as they exhaust their COBRA coverage, change jobs, leave jobs or leave to start their own businesses. Delaying implementation of the key portability provisions would mean that many more Americans may be forced to pass up opportunities to accept new jobs or see other opportunities because they are afraid they will lose their health insurance. Many others will lose the protection that last year's legislation provided. Congress promised these protections to the American people, and Congress should keep its promises.

I thank the chair.

The CHAIRMAN. Thank you, Senator, for an excellent statement, and I congratulate you again on the passage of this legislation.

We will begin the hearing this morning with our first panel, which includes distinguished members from the three Federal departments responsible for writing the health insurance regulations.

I will introduce each guest and then begin with testimony. The first witness will be Mr. Bruce Vladeck, Administrator of the Health Care Financing Administration since 1993. Mr. Vladeck directs the Medicare and Medicaid programs and serves as the key health policy advisor to the Secretary of Health and Human Services and other top administration officials.

Mr. Vladeck, thank you for being here, and please proceed.

Senator MIKULSKI. Excuse me, Mr. Chairman. I know we do not have opening statements, but I would like to ask unanimous consent that I have one included for the record.

The CHAIRMAN. Certainly. It will be included in the record without objection.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

I am pleased that the Labor and Human Resources Committee is addressing the status of HIPAA—the Health Insurance Portability and Accountability Act of 1996. HIPAA will open new doors to many Americans currently trapped by the existing health insurance system.

HIPAA will make health insurance portable; it will provide health insurance to people with preexisting conditions; and, it will make health insurance more available to working Americans. But, to be successful, implementation of HIPAA requires a tremendous

amount of work in a very short period of time. Successful implementation requires extensive work at the federal, state and community levels. Successful implementation requires coordinated efforts to ensure that the intent of this law is met.

Although I strongly support this law, I am concerned about one of the provisions. Section 217 would criminalize the transfer of assets to qualify for Medicaid coverage of long-term care. think this provision is unnecessary. Medicaid law already penalizes such transfers of assets—Medicaid eligibility is delayed.

The provision makes potential criminals out of frail older citizens who need nursing home care. Older people are concerned that an innocent gift to a grandchild will make them criminally liable if they may someday need to go to a nursing home. This section of the law is confusing to older people and their families. We need to take another look at what we've done in that section.

I want to thank Senator Jeffords for affording us the opportunity to oversee the implementation phase of HIPAA. I am proud to be a part of this oversight process. I look forward to the testimony from all our witnesses.

Senator MIKULSKI. And Mr. Chairman, I would note just one other flashing yellow light on the implementation of this legislation which I think deserves attention, which is the whole issue of criminalizing the transfer of assets by older people. That is a very complex subject, not easily remedied, but I just want to say I think that that is one of the yellow flashing lights.

I look forward to hearing the testimony.

Thank you.

The CHAIRMAN. Please proceed, Mr. Vladeck.

STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. VLADECK. Thank you very much, Mr. Chairman, and good morning to the members of the committee. It is a particular pleasure and privilege for me to have the opportunity to appear before you this morning, our first experience with this committee in some time, and a particular pleasure to be here with my colleagues from the Departments of Labor and Treasury, with whom we have been working arm-in-arm on the implementation of this very important new legislation.

I do not have to tell any of you that the Health Insurance Portability and Accountability Act of 1996 enhances the portability of health insurance to permit many workers to maintain coverage when they lose or leave their jobs.

The Department of Health and Human Services, through the Health Care Financing Administration, has been given a significant role in implementation of this law, and we applaud the committee and the bipartisan effort in the Congress that produced this very important legislation and that continues to be so interested in its implementation.

This activity requires us at the Health Care Financing Administration to assume a whole set of new roles in relationship to State regulation of health insurance and health coverage. These roles are consistent with our commitment to improve access to health insur-

ance to all Americans but have required us to learn an awful lot about activities in which we have not been very much engaged in the past.

In recognition particularly of that, we have been engaged in an extensive series of meetings with States, insurers, advocacy groups and the public to learn as much as we can from them as we prepare to implement the law.

My colleagues from the other departments will discuss in greater detail a number of the questions concerning the process of our collaboration and our working together to meet the deadlines in the law and to carry out our shared responsibility.

I will focus very briefly on our particular responsibilities in terms of the group and individual insurance markets. But let me emphasize again that the requirement under this law that we assume new roles in relationship to State regulation of health insurance and health coverage has caused us perhaps even more than we otherwise would to work especially closely with the States and with the National Association of Insurance Commissioners in promulgating the regulations.

We have met with many State groups such as the National Governors Association, the National Association of State Medicaid Directors, the American Public Welfare Association and others, but I have to particularly acknowledge the excellent work and assistance that we have received from NAIC and the extent to which we continue to rely both on their leaders and on their staff for their excellent work.

We understand that responsibility for overseeing the action of insurers offering coverage in the group markets rests with the States and not with the Department of Health and Human Services. The States have the expertise and the depth of experience necessary to successfully fulfill this role.

The National Association of Insurance Commissioners has been taking the lead in working to identify the changes in their model laws and regulations that will be needed to assist States to conform with the HIPAA provisions. They have assembled a significant body of advice for the States which they have shared with us, and we expect that that advice along with our April 1st regulations will permit the States and the insurance companies to achieve timely and effective implementation of the law.

It is important to note in this regard that States are not required to send us their updated group market laws or regulations, and we have no authority on the group side to approve or disapprove them. We do have the authority to intervene if a State is not substantially enforcing a provision of the law, but we intend to continue to work closely with the States to minimize the chance of such an eventuality.

Our role in the individual insurance market is a little more proactive. HIPAA incorporates provisions to ensure access to the individual market on a guaranteed issue, guaranteed renewal basis without preexisting condition exclusions for eligible individuals as defined by the law. Again, we have been given responsibility for these provisions.

However, the implementation, as was mentioned in both your statement and that of Senator Kennedy, is closely tied to the cer-

tification of creditable coverage as provided for in our shared efforts with our fellow departments. Thus we are working very closely with them on that part of our regulations through our interagency working group.

In drafting the individual market provisions, Congress deferred to the States in the regulation of insurance and afforded the States great flexibility. We believe this is appropriate since there is great variation among the States in the characteristics of their health care markets or their health insurance markets and in their previously existing rules for the individual market.

In the individual market regulations which will be issued on April 1st, we will emphasize that States do have a choice to implement an alternative mechanism or to implement the Federal provisions. As in the group market, we will continue to consult extensively with the States as we formulate these rules.

However, due to the effective dates and deadlines in the law, States cannot wait for our regulations to be issued to develop alternative mechanisms to assure either group or individual portability in the individual market. The law, as you know, is effective on July 1st of this year, and our regulations are due for publication on April 1st. Therefore, a State can submit a notice to us by April 1, 1997 indicating the State's intent to implement an alternative, including descriptions of its proposed mechanisms and its implementation plan, for implementation any time prior to January 1, 1998.

Recognizing that the States have many questions about the law and the information we will need with which to review their alternatives, we issued a notice on January 13, 1997, offering guidance as to how to proceed in the absence of regulations. This notice sought to express substantial flexibility in both documentation and in the range of mechanisms that we would view as acceptable, while at the same time strongly noting our commitment to assuring that eligible individuals have access to coverage within the terms of the law.

We realize that the implementation time frames in the statute represent a significant challenge to the Governors and the State legislatures. We have already indicated our intention to be flexible in regard to good faith State efforts to meet these deadlines. Given what is at stake, it is imperative that we continue to work with the States so that the workers and their families can benefit from this law as soon as possible.

We see no contradiction in our commitment to permit the States as much flexibility as possible and recognize their primary responsibility in this area while maintaining our responsibility to see to it that these very important protections in Federal law are observed and maintained; nor do we believe that any statutory delays are warranted at this point.

You have asked, Mr. Chairman, if there is anything that you or this committee can to do help. At this point, I am pleased to say—and I think my colleagues will agree—that we do not believe any legislative changes are needed for initial implementation of the legislation. We will continue to listen and work with the States, the public and other affected parties with respect to all of the provisions in this law, and I expect that over time, we will probably

identify areas where we will need to discuss further legislation, but we have not done so to this point.

Again, in conjunction with our sense of challenge and of the amount of work we have to do to assume our responsibilities under this legislation, we are very pleased and privileged to have the opportunity to participate in this pathbreaking set of activities, and we very much appreciate your continuing leadership.

I think it is probably appropriate to hear from my counterparts in the other agencies and colleagues, but at whatever point you would like to ask questions, we are delighted to respond.

The CHAIRMAN. We will hold questions until the last of the testimony. Thank you.

[The prepared statement of Mr. Vladeck may be found in the appendix.]

The CHAIRMAN. Our next witness is Olena Berg, who is serving in her fourth year as Assistant Secretary for the Department of Labor's Pension and Welfare Benefits Administration.

Assistant Secretary Berg is responsible for the administration and enforcement of the Employee Retirement Income Security Act.

Welcome. Please proceed.

STATEMENT OF OLENA BERG, ASSISTANT SECRETARY OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF LABOR, WASHINGTON DC; AND J. MARK IWRY, BENEFITS TAX COUNSEL, U.S. DEPARTMENT OF THE TREASURY, WASHINGTON, DC

Ms. BERG. Thank you, Mr. Chairman and members of the committee. I too would like to add my thanks to this committee for the hard work that you did in passing this landmark legislation and particularly for your continuing interest in its implementation and the assistance that you have been giving us.

I am especially pleased to be here with my colleagues this morning because as you have already begun to hear, the overlapping responsibilities that have been given to the three departments by the legislation have indeed required that we work very closely together, and we have been doing so.

In fact, you have probably already noticed if you have had the opportunity to read our written submissions that there is as a result of this coordination a substantial amount of overlap. So we have tried a little bit this morning in our brief remarks before you to limit that and divide this out, but I think you will hear us stressing some of the same points again, and I apologize for that if we do.

What I would like to do is give you a very brief overview of the group health portions of the legislation where we have overlapping responsibilities. I will ask my colleague Mark Iwry to go into a little bit more detail on the process that we are working through, and of course, Bruce Vladeck has already given you more information on HIPAA's provisions that relate to the small group and individual insurance markets.

Before I go into this brief overview, I would like to very briefly and very directly address the questions that you posed to us in inviting us to testify this morning. The first, of course, was about the process, and we will go into that in a little more detail, and about

the consultations that we have been having with the private sector and other affected parties.

On that question, I think I would really like to have the rest of the testimony that you will hear this morning speak for itself. We have been talking to many groups who are affected by this. We have been trying to listen and to be flexible, and I hope that that will be reflected in the testimony you hear this morning.

With respect to your other questions, the next was difficulties that we might foresee with respect to implementation of the law. As Senator Kennedy has already pointed out, there are very tight time frames that have been given to us for the implementation of HIPAA, and that was for the reason that we want to ensure as rapidly as possible that American workers and their families are afforded the protections of the statute. And the schedule that has been provided here does impose challenges for us, but in short, we are progressing, and we see no reason why the law cannot be implemented just as prescribed under the time frames given.

Finally, you asked us what Congress can do to assist in resolving any problem areas. Again, at this point—and Bruce Vladeck has already underscored this—we have not found any areas that need to be corrected in order for us to go ahead with the implementation of the law. Things may come along as we move along, but there is nothing that should impede us now from being able to act.

Now, again, with respect to HIPAA's specific provisions, the Act, as you know, provides for Federal portability requirements for group health plans and group health insurance coverage. These provisions are set forth in amendments to ERISA, to the Internal Revenue Code and to the Public Health Service Act.

As we have noted, we have shared responsibilities among the Secretaries of Labor, Treasury, and Health and Human Services for most of the group market provisions such as those that address, for example, preexisting condition limitations. There are other provisions that we have primary responsibility for in the Department of Labor, for instance, some of the disclosure provisions, and there are many that fall within the jurisdiction of two out of the three departments. So that as you ask your questions, we will probably try to direct those to where they will be most appropriate. But we are coordinating all of these various aspects of the law. Again, the primary focus of our joint activities is guidance with respect to the portability provisions that will now limit the ability of group health plans and health plan insurers to impose preexisting condition limitations.

Moreover, as you know, even where a preexisting condition exclusion may be imposed, it can be no longer than 12 months in most cases, and this 12-month exclusion period must be reduced by the length of certain previous health coverage.

Now, in order to effect these provisions of the law, participants will receive a certification from their previous group health plan or health insurer in order to receive credit for that previous coverage, and it is this process of providing the evidence of previous coverage that we are going to be addressing in the regulations we will issue by April. This is extremely important in terms of the time frame because plans will begin to be subject to the portability provisions

as soon as a new plan year starts after June 30th, 1997, and so they will need this guidance.

On the other hand, we need to point out that most plans will not be subject to the new requirements until January 1, 1998, so there will be time to see how well the guidance that we have given is working. And again, Mark Iwry will talk about the process in greater detail.

Again, I appreciate the opportunity to talk about the rulemaking process and to again assure you that we are working diligently on a rapid implementation of HIPAA's protections.

I would like to note also that by providing this forum this morning in which we can share these comments, you have already contributed significantly to our efforts, and we intend to take the public record of this hearing and make it a part of the formal record of our rulemaking process as well.

Thank you very much, and I too will be pleased to answer any questions you may have.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Berg may be found in the appendix.]

The CHAIRMAN. Our next witness is Mr. Mark Iwry, who is the Benefits Tax Counsel at the Department of the Treasury. Mr. Iwry is the principal legal advisor to the Secretary of the Treasury and the Assistant Secretary for Tax Policy with regard to all aspects of employee benefit taxation and related matters, including pensions, health care, and executive compensation.

Welcome, and please proceed.

Mr. IWRY. Thank you, Mr. Chairman and members of the committee. I am pleased to appear before you this morning to present the Department of the Treasury's views on the implementation of the group market portability provisions of the Health Insurance Portability and Accountability Act.

As you know, this legislation was enacted on a bipartisan basis with the strong support of the administration. It provides important insurance reform that enhances health care coverage for working Americans.

We commend this committee for its important role in achieving passage of this law. As my colleagues, Bruce Vladeck and Olena Berg, have indicated, HIPAA added very similar group market provisions in three separate statutes and created shared responsibility for these provisions among the Departments of Labor, Health and Human Services and Treasury.

I have submitted a longer statement for the record, and my oral remarks will focus on the process that the departments have been following in developing the regulations under these shared provisions.

Congress established a compressed timetable for implementation of the HIPAA portability provisions for the reasons Senator Kennedy mentioned, directing the three departments to issue, first by April 1, 1997, such regulations as may be necessary to carry out the provisions of the group market rules.

Personnel from all three departments met directly after HIPAA's enactment and quickly established a working arrangement for the development of regulations to be issued by April 1. Staff from each

department including, in the case of the Treasury, staff from the Internal Revenue Service, have been assigned to a number of interagency teams. These interagency working groups take responsibility for portions of the necessary regulations.

After collectively analyzing the issues, members of each working group developed an initial draft of their portion of the regulations. Each group then began working to resolve outstanding issues and revise their draft.

A larger interagency group is also involved in reviewing the draft regulations, in addressing issues that have been identified by the working groups and in coordinating the overall regulatory project.

Once the work has been completed at the staff level, the draft regulations will be reviewed by each department and will be submitted to the Office of Management and Budget for review before publication.

After the regulations have been issued, we intend to establish procedures under which regulations, rulings and interpretations relating to these shared provisions will be administered so as to have the same effect and to establish enforcement priorities that will be coordinated to avoid duplication of effort and assign enforcement priorities.

We expect the regulatory process to provide us with insights as to the most appropriate roles for each agency and potential approaches to the allocation of interpretive authority and the coordination of enforcement policies and priorities. Once the initial regulations are finished, the agencies will be in an improved position to develop a formal memorandum of understanding that specifies the allocation of responsibilities for future administrative guidance and enforcement.

Accordingly, the agencies intend to complete and execute a memorandum of understanding by building on the operational understanding that already exists among the departments with respect to the drafting of the initial regulations.

Development of a single set of HIPAA regulations by three departments on a collaborative basis is neither an easy nor a simple task. The process has led us to appreciate better the challenge that this committee and the other congressional committees of jurisdiction confronted in crafting the legislation, but we do believe that the process of developing the regulations is proceeding well. The interagency teams are working diligently and in a spirit of cooperation. Substantial progress has been made in developing the regulations on the shared group market provisions, and we do believe that the regulations are on track to meet the April 1 goal.

A guiding principle for us in the process of developing regulations has been to implement the provisions of this legislation in a manner that will be faithful to the statutory provisions and protections for workers and their families while also remaining sensitive to the burdens that could be imposed on employers, plans, insurance carriers and others.

During this process, we have taken into account comments from the public, and we will continue to do so. We regard the consideration of public comments both on behalf of employees, dependents and others seeking health care coverage and on behalf of employ-

ers, plan administrators and issuers of insurance as a key component of our implementation efforts.

The personnel from the agencies have been meeting with a considerable number and variety of outside groups, participating in conferences and panel discussions, and receiving and responding to correspondence and telephone inquiries regarding the group market provisions. This has helped inform agency personnel about the concerns of those affected by these new requirements.

In addition, last December, as you know, the three departments published in the Federal Register a public solicitation of comments on the HIPAA portability provisions. This was designed to get the broadest range of information and views from all affected parties and to make sure the public knew we did welcome further comments on all issues under the portability provisions in order that comments could be taken into account to the extent practicable before the regulations are initially promulgated by April 1, 1997.

This open comment process has provided the departments with valuable information. We also intend, of course, to make the public record of this hearing a part of the record of our rulemaking, as my colleague, Ms. Berg, has mentioned.

In conclusion, this legislation brings about important reforms that the agencies are working hard to implement in a way that will be faithful to the statute and to its purposes. In so doing, we are mindful of the desirability of fulfilling the statutory protections while avoiding unnecessary or unworkable burdens on employers, insurers, plans or others.

Once the initial group market portability regulations have been issued, the agencies will continue to take into account comments from all the affected parties as we consider whether changes should be made to the regulations or whether additional guidance ought to be issued. We do hope that Congress will continue to work with the administration on a bipartisan basis to make health care coverage more accessible and more secure for all Americans.

Mr. Chairman, I appreciate the opportunity to testify before this committee and will be pleased to answer any questions you or other members might have concerning these matters.

[The prepared statement of Mr. Iwry may be found in the appendix.]

The CHAIRMAN. Thank you. That is very helpful testimony, and I want to say to all of you that I commend you on the expeditious way that you are moving forward on this very important legislation, and I am hopeful that we will continue to proceed at that speed, although I know it is quite complicated as we get into the implementation of the regulations.

Mr. Vladeck, in your testimony, you indicated that you issued a comment notice in the Federal Register on December 30, 1996, with a due date of February 3. Have you received any comments, and if so, what issues do the majority of the comments raise?

Mr. VLADECK. Yes, sir. We received I believe close to 300 comments, perhaps somewhat more than 300 comments, the great majority of which raised questions about the treatment of college health insurance plans, which frankly was not an issue we had anticipated in our initial work with the statute and one that we are still trying to work our way through. There was a broad range of

other issues and concerns raised as well, but clearly the most numerous comments had to do with the health insurance plans that colleges have offered or established for their students.

The CHAIRMAN. Just as a matter of information, are you still receiving comments? Will you still accept them, or is it too late now?

Mr. VLADECK. No. Absolutely, we are continuing to hear from all sorts of folks and to incorporate their comments and their concerns and observations in the work that we are moving forward on.

The CHAIRMAN. You indicated that although we have the authority to intervene if a State is not substantially enforcing a provision of law, we intend to work closely with the States to minimize the chance of this happening. I feel that this is a very important point. Could you please expand on your statement and provide me with more information on the steps you are taking to try to prevent this from happening?

Mr. VLADECK. Well, again, I think we have been very fortunate in the kind of leadership that the National Association of Insurance Commissioners has demonstrated in working not only at the policy level across the Nation but with individual States to identify issues or concerns that they might have and to seek to provide those States with the assistance they need to come into compliance.

Our major philosophy about our responsibilities under this legislation is that the people of this country or of any given State are benefited most to the extent to which States adopt policies and regulations that are consistent with the purpose and the specifics of the law and that in fact more direct Federal intervention in most instances would probably slow down the ability to bring about the necessary changes rather than to accelerate it.

So we believe that in the overwhelming proportion of cases, these issues will take care of themselves; the States will make the changes that are necessary to come fully into compliance with the expectation of the laws, and that if there are instances in which that does not happen, we will take the opportunity to work directly with those States to try to ensure compliance rather than seek to intervene more directly.

We will retain that responsibility in the hypothetical instance that it becomes necessary, but we are hopeful and very much intent not to take on this new line of business for ourselves.

The CHAIRMAN. All right. In your testimony, you mentioned the issue of certification of creditable coverage. I think this certification is potentially going to be the most difficult of the areas of implementation for the three agencies to address, so I would appreciate your sense of the difficulty and progress in this area.

Mr. VLADECK. Let me defer to my colleagues who have been more fully engaged in this particular part of the issue if I may, Mr. Chairman.

The CHAIRMAN. Certainly.

Ms. BERG. Yes, Mr. Chairman. Had you asked me on the comments, what were we getting comments on, it was exactly that area. In particular, there is a transition period because the law requires that individuals who since October may have left their jobs and moved out of a health care plan will be entitled to certification of their coverage, but that certification will not be issued until after June, when the requirement takes effect. So the question is, for the

many health care plans that are, number one, trying to keep track of these things, how much paper will they have to issue at that point; if they had not in the past been keeping track of dependents for example, how will this information be provided.

We think these are all transition sorts of issues because when we come out with the regulations for what is required in the certification, and plans know what they will need to be doing in the future, again, we will try to keep that simple and easy to comply with.

In the meantime, we think the law has given us all the flexibility that we need to deal with these transition issues. We can in the regulations provide, for example, that individuals may be able to provide evidence of their coverage during this period of time if the plan does not have records. There is, of course, the good faith compliance provision in the law. We think that by fully utilizing the flexibility you have given us, we will be able to take care of these concerns in a way that is not burdensome.

The CHAIRMAN. Mr. Vladeck, although you did not comment on this at length in your testimony, what about the individual market provisions of HIPAA, and in general terms, how the agencies tend to approach these aspects?

Mr. VLADECK. Well, again, Mr. Chairman, I think it has been the individual market issues on which we have been the most focused and that has been the focus of much of our conversation with the States.

My most recent conversations both with our staff and with the folks from the associations suggest that the overwhelming majority of the States are at the moment in the process of either contemplating new legislation or discussions between their executive branches and legislatures or looking at their existing policies on the extent to which they are consistent with HIPAA. And again, I suspect that over the next 2 or 3 months, we will be able to identify almost all, and I would hope all, of the States as being on track to meet the requirements by this summer.

The CHAIRMAN. Mr. Iwry, on page 5 of your testimony, you indicate, "These new enrollment rights, especially in conjunction with the new limits on preexisting condition exclusions and existing COBRA rules, will enable employees and dependents to enroll when they need coverage, provided they can afford the coverage and understand their rights."

There is a lot that is said or implied in your statement, and I wonder if you could elaborate on the difficulties you see here.

Mr. IWRY. Mr. Chairman, I think what these provisions will call for on the part of individuals who have these rights will be decisions, for example, as to whether to continue on COBRA or move to a new employer's plan in many cases, and in those cases, they will need to understand something of how the rules work—for example, that the COBRA rules would typically cut off the COBRA coverage when someone is covered under a new employer's plan, that that is not the case, however, if there is a preexisting condition exclusion in the new employer's plan, that if the HIPAA provisions cause the elimination of the preexisting condition exclusion in the new employer's plan, then the cutoff of the COBRA coverage does, as you know, occur, and there will be a variety of factors that

an individual will have to take into account in making those kinds of decisions—do I go on COBRA in the first place if I have a new employer plan available to me; if I have started on COBRA, and I have not enrolled in the new employer plan promptly, can I later switch to the new employer plan, either when the normal open season occurs in that plan or on a special enrollment basis, can I get into that plan when I need to. There is also the issue of having to exhaust COBRA coverage before one can get into a new plan as a special enrollee.

So we were simply observing that there is a variety of factors that people will have to take into account, depending on their particular circumstances, and we are certainly going to do our best to craft the regulations in a way that is as workable as possible for individuals as well as for the entities that are involved in administering all of this.

The CHAIRMAN. I assume you will provide some questions and answers or information for people to look at. How are you going to try to help them understand what to do?

Mr. IWRY. We have not yet made any firm decisions as to what we will do in that regard, but we are sensitive to the fact that individuals will have a lot to think about and will need to understand a number of basic elements about the rules in order for all of this to really work well.

If I may, let me just add in the related area of certifications that you brought up earlier, we have given considerable attention to the possibility of facilitating the way these rules are implemented through a model certification, and we have suggested to the public, through the Federal Register notice that we put out, that we would like to know whether people think that a model certification as a way of standardizing what issuers and plans have to certify to, what information has to be provided, and as a way of making it easier for the receiving plans to take in that information and to digest it quickly, whether that would be helpful and would promote the protection of rights for the individuals as well as be a more efficient way of regulating this certification system, and we are getting input on that and are having a dialogue with a variety of affected parties on that.

The CHAIRMAN. Senator Kennedy?

Senator KENNEDY. I am glad we gave you a lot of flexibility to deal with some of those issues that you have just outlined here because they get into enormous complexity, and we can pass legislation, but it is really important that we are able to respond to real human needs in these circumstances, and obviously, you are giving good attention to it, so we are very hopeful.

I note, Mr. Chairman, that this is one of our first meetings, if not the first, with representatives from the Health Care Financing Administration. Now that we have you in front of us, I am sure there is a wide range of health policy issues, but we are always glad to have you, and I think all of us have had the opportunity with Mr. Vladeck on many occasions as well as other members of the panel to draw on your expertise and help as we have been trying to work through some of these measures.

And I am very, very grateful to you, Mr. Iwry, and thank you very, very much for all of your help not only on this legislation but on some of the other; and I thank Olena Berg as well.

As has been pointed out, the legislation passed in August, and in December and early January, we tried to indicate to the States, as I understand, what would be expected out there from the States, and there have been good exchanges taking place, so we have been giving notice over the period of time.

As I understand it, the States that have a short legislative session may not be able to develop the alternative mechanism in time for the April 1st deadline. States, as I understand it, can come in later if they notify the Secretary that the State is developing an alternative mechanism, is that right, so they can come in—they notify you, but they can still come in with their own kinds of protections.

Mr. VLADECK. Yes, Senator, and in fact what we are most interested in, I think, both under the law and as we have made clear we will interpret it, is evidence that given the constraints of their legislative processes or whatever the States are seeking to move in the direction called for by the law, and that will take us quite some way down the road if there is such movement, even if it is inconclusive because the legislature has already adjourned or whatever other events may have prevented that from happening in terms of those initial timetables.

Senator KENNEDY. There has been a question, as I understand, from some States who have submitted notice to you by April 1st for an alternative mechanism but do not match the requirements of the April 1st final rule. As I understand it, we tried in the language to make it clear as to what was expected, and then, through the workings of your joint committee, tried to indicate to the States in December/January what was expected.

Do you think that there is sufficient information out there for the States to be able to anticipate what will be the April 1st judgment so they will be in conformity with that judgment?

Mr. VLADECK. Senator, we are hopeful that is the case, but I would certainly not want to assume it or take it for granted. It is one of the reasons we have tried to make clear for the States that if, again, their legislature has already acted for this year or some other events occur before April 1st, and then the regulations turn out in some way to differ from actions they have already taken. What we are concerned about seeing is some indication or evidence on their part of putting in place the processes necessary to eventually come into compliance with the regulations and in an appropriate time frame, rather than letter-perfect compliance with regulations before they are issued.

So we anticipate that we will be able to work those out in most instances relatively straightforwardly.

Senator KENNEDY. There is some concern by some States about the amount of information that is required in the December guidance put out by HHS about what information must be submitted by the States. Do I understand that you are willing to work with the States to make sure we get adequate information to conform with the legislation but that it is not overly burdensome?

Mr. VLADECK. Well, Senator, I must say I think we may have failed to convey what we were trying to do. We were trying to make this process easier, and I am afraid that by some States, it was perceived that we were making it more difficult.

Again, this is a new area for us. We are not expert in existing State insurance law and insurance regulations. It is our expectation, I think, and the clear intent of the law, that we are trying to see to it that States in their infinite variety find ways to be consistent with the law and that we are not seeking to use a fine-toothed comb in evaluating their compliance with it. But as part of that, we had hoped to have a process in which we would have to be back and forth with the States as little as possible so that whatever submission they made to us on April 1st or thereafter, we could evaluate as quickly and as painlessly as possible without having to pick up a phone and say, You referred to this document or that document which we do not have; can you send another set, prolonging the process in that way.

I think given the way in which that notice was perceived, we have been at pains to communicate to the States that, no, we do not want to have them ship the entire contents of the State library to us; they need to help us, frankly, understand what it is they are doing because this is not an area in which we have a considerable track record, and we would like to make that a straightforward process for everyone.

And we will learn this as we go, but we hope that in practice this will not turn out to be a burdensome requirement at all.

Senator KENNEDY. Well, I think that that is important. We obviously want to get the compliance, but we also want to have a situation which as I understand is taking place, the flexibility and the desire to work with the States to try to help those that are moving and developing the alternative mechanism and permit them to do that in a timely way. That is clearly our objective.

When there is a change in the Tax Code that includes new penalties under the IRS, how do you let people know about it? How do you notify potentially affected parties about the change?

Mr. IWRY. Senator Kennedy, there is not a standard public notification beyond the normal statutory processes until the tax forms come out. At that point, typically, the taxpayers are informed as part of the instructions to new forms, but oftentimes the Internal Revenue Service will issue special administrative guidance or notices or announcements, news releases and the like if there seems to be particular reason to get the word out on a wider basis or in a more conspicuous way than normal.

Senator KENNEDY. Do you anticipate that with regard to this legislation?

Mr. IWRY. That is something that we do have under consideration as part of the overall strategy of implementing the legislation in a way that works and that gets the word out to all the relevant affected parties.

Senator KENNEDY. Just a final question, briefly, because I know others wish to question. We want to give the protection of certain rights to individuals with this legislation. How are we going to get that information to the individuals so they know their rights are

being protected? How do we do that? Maybe we could start with you, Ms. Berg.

Ms. BERG. Certainly, Senator Kennedy. We have already begun thinking about that because as I think has already become apparent, there are many important decisions people are going to need to make with respect to their health care as a result of the new legislation, and we promptly, based on the questions we started to get right after the passage of the legislation, put out a booklet in December, "Questions and Answers to the Recent Changes in Health Care Law." We have already distributed over 26,000 copies of this booklet, and we expect to be updating it regularly as we proceed in the process, more information becomes available and we begin to learn more about what kinds of questions people are asking.

We have made major strides in the last few years in upgrading our customer service ability within PWBA so that now, all of our 15 offices around the country will help participants with their questions and concerns, and we do in Washington as well.

We have also developed a tracking system so that we will know the questions that people are asking us and will be better able to target the guidance that we give in publications like this to people.

Now, the other major source of information for most people on these sorts of issues is, of course, their employer or the health care plan itself, and we started down that track as well, providing information to try to be helpful to the employer community in providing guidance there as well. So that for instance, in speeches and outreach that we do, we are going around to 10 different cities, participating with the International Foundation of Employee Benefit Plans, giving guidance to plan sponsors, and we will address these kinds of questions in those venues as well.

Senator KENNEDY. Mr. Vladeck or Mr. Iwry?

Mr. IWRY. If I could add, Senator, in addition to the Q and A booklet that the Department of Labor issued which Ms. Berg referred to, in mid-October, the three departments worked together to develop a notice advising employers of the new COBRA changes that are of course related to all of these portability provisions. The Department of Labor issued that notice on October 15th, I believe, and that is something that is usable for employees as well as part of the effort to implement this in an efficient way. The notice said that if an employer wanted to use this notice as is in communicating with employees or take the language from it verbatim for employees, it could do that. It was written in a way that was intended to be as user-friendly as possible.

If I could just add one other point, we also expect that the process of certifications being provided from plans and issuers to individuals will really get the ball rolling in terms of educating people as to their rights. When they get that information from the plan, we think that that will have an impact and that people will start to take a further interest in what their rights are and in how those can be implemented.

Mr. VLADECK. Senator, there is obviously enough concern on the part of many families about these issues and enough visibility, appropriately, to the enactment of this legislation that well before any actual implementation, we had already begun to receive a

number of inquiries from folks about where to turn and how to go and so forth.

Over the last decade, through our shared responsibilities for Medicare supplemental policies, we developed relationships with State insurance departments and consumer groups to provide for various kinds of consumer-related information, and we would hope to be able to build on those. Again, since the specific answers for most consumers will be in their States in many instances, that is on our agenda with the NAIC once we get the States up and running.

Senator KENNEDY. Thank you very much. I want to commend all of you for your work on this proposal. It was complicated and difficult, but it certainly sounds like you are carrying through the intention of the legislation and trying to do it with maximum flexibility. It was impressive testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Enzi?

Senator ENZI. Thank you, Mr. Chairman.

I have had the opportunity to review this legislation as a State Senator with the Labor, Health and Social Services Committee of the Wyoming Legislature as we tried to decide what needed to be done and also through the COBRA provisions that I have worked with as an accountant for small business in Wyoming.

I am pleased with the Health Insurance Portability and Accountability Act because it addresses some of the most serious obstacles that restrict group and individual health plans, and the provisions in this bill do make insurance portable. It guarantees the availability and renewability of coverage, and the Act prohibits discrimination on the basis of preexisting medical conditions for people who maintain their continuous coverage, and that is important.

The Act also makes it easier for small businesses to voluntarily form purchasing cooperatives, and I think that that will solve a lot of problems. Those are changes that most people agree are needed.

I am hoping that the administration will act cautiously when administering the new law. It was the result of a lot of hard work and bipartisan coalition. The measure could have been tossed on the great scrap heap of unfinished business, but differences were set aside to produce a respectable law, and that is the kind of action that I think the American people are asking us to do.

When I meet with people in Wyoming, the message I come away with is that they want action; they are not interested in rhetoric or excuses or partisan bickering. They have asked for health insurance reform, and Congress has delivered. Now the torch is passed to you.

I do not envy your job. You have to write with the technicality that insurance companies understand and deserve, and a lesser degree so that States will be able to implement, and you have got to be able to write it so that the companies can follow up on it and yet the individual who is going to be the ultimate beneficiary will be able to understand and be able to protect himself and take advantage of this landmark legislation.

So I congratulate all the people who have worked on this.

I am concerned a little bit about some of the words that are used in this, and I would like to ask you how a "good faith effort" will

be defined in regard to a State bringing the law into compliance. How are you going to evaluate this good faith effort?

Mr. VLADECK. Well, Senator, we are going to try to avoid semantics. I think we are going to presume that most efforts are in good faith. Our understanding of the mandate from the Congress and of the intent of the law, and certainly our conversations with the States—I would think that a State that was doing nothing whatsoever to seek to come into compliance with the legislation would not be making a good faith effort, but we will assume that just about any efforts that the responsible parties, whether they are in the executive branch or an independent insurance department or in a legislature, are making to see to it that the State laws are in compliance with the mandates of HCFA would constitute such a good faith effort.

We are not going to try to second-guess the quality of faith in that regard at all.

Senator ENZI. Do other panelists wish to respond on that?

Ms. Berg?

Ms. BERG. Well, I think I can only second that. We are going to be looking at good faith, again, as broadly as we can, and of course, our area of interest is primarily the certification of coverage and how that evidence is presented. To the extent that health plans do not have records, again, we will see if individuals may have copies of expenses that were incurred, and we can look to plan documents. Whatever is there, we intend to try to take the broadest view, because the most difficult period will be this initial transition period until everyone adjusts to the new system.

Senator ENZI. Another word is "substantially." If a State fails to substantially enforce one of HIPAA's provisions, will the Secretary apply pressure to correct the failure of that one provision, or will it result in oversight of the entire State's program—or will there be some definition of this term "substantial"?

Mr. VLADECK. Again, Senator, I think that both our intention and the track record is that our interest is seeing to it that States carry out the purpose and the specifics of the law as much as they can. We are not looking to conduct enforcement for the sake of enforcement or to take any greater responsibility in the regulation of insurance in any given State than is absolutely necessary in order to meet our obligations under the law.

So our strategy is one around assuming or expecting compliance in the great majority of the instances, and when it is not arriving for whatever reason, to work with the States as best we can to bring the States into compliance. That is the strategy and the philosophy we are adopting toward our responsibilities in that regard.

Senator ENZI. Thank you.

Since this is complicated and involves the Departments of Labor, Health and Human Services and Treasury, I am a little concerned with the process getting all tangled up. Do you feel confident that you have policies in place that will ensure that this does not occur even prior to the memorandum of understanding? It sounds like it is all proceeding—I guess I want a little reassurance on that, too, that it is proceeding on track to have the regulations done by April 1st. But I will add another little question to that—if they are not

done by April 1st, what concessions are going to be made to the States?

Ms. BERG. We fully anticipate having the regulations available on April 1st, but to some extent this will be an iterative process. We also fully intend, once the regulations are issued and the guidance is out there, to get more comment and if necessary make changes to specific provisions as we get more and more experience.

As I mentioned earlier, group plans, for instance, will be coming into compliance in stages. The first plans, we estimate from reviewing the Form 5500 data that we have available that about 10 percent of plans will become subject to the law's requirements this summer, and then about another 15 percent or so, whenever their plan year changes, until the end of the year. The bulk of plans, about 50 percent, will have to come into compliance on January 1st, and the remaining quarter will again sort of dribble in during the next 6 months after that.

So that as plans begin to work with the requirements and give us comment back, we will have an opportunity to continue to refine the requirements.

Mr. IWRY. With respect to the coordination, Senator Enzi, so far, so good. Things are working very smoothly in the development of the regulations.

We have started work on the development of a memorandum of understanding that would address the issues of enforcement coordination and coordination of more specific interpretations that will follow the promulgation of regulations. That work still for the most part lies before us, but we are optimistic, based on our experience to date, that we will be able to work out procedures that do coordinate in an efficient and effective way.

Senator ENZI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Reed?

Senator REED. Thank you, Mr. Chairman. I have just few questions.

I believe it was mentioned previously about provisions in the law with respect to Section 217, which indicates that there is a criminal penalty established for knowingly and willfully disposing of assets in order to gain eligibility for Medicaid. I wonder if you could comment on how you are dealing with this issue. Obviously, no one wants to see anyone move assets around to avoid their legal responsibilities, but there is also the possibility of generating a concern among the elderly that normal distribution of property could fall under this criminal proscription. I wonder if you could comment.

Mr. VLADECK. Senator, we do believe that there has been a lot of fear and anxiety created by this provision. We do not believe that it is necessary in order for States to have the tools they need to enforce limitations on inappropriate transfers of assets, and we are exploring at the moment the best way to undo, frankly, that part of the legislation.

Senator REED. Thank you for that interesting answer. Would anyone else have an equally compelling and interesting response?

Mr. IWRY. That is not within our jurisdiction, Senator.

Senator REED. That is the best response. [Laughter.] You must be a lawyer.

Let me ask you about something that is within your area of expertise, and that is the medical savings account, which is part of the legislation. I wonder if you could generally describe your efforts to set up this pilot program so that it falls within the confines of the pilot program; if you could do that, I would appreciate it.

Mr. IWRY. I will be happy to do that, Senator Reed. I will just note that the letter of invitation from the committee as we understood it indicated that the hearing would be focused on the portability provisions, and committee staff advised us to the same effect, but notwithstanding that, I would be happy to respond to your question.

Senator REED. If the chairman feels that traipsing over the boundary——

The CHAIRMAN. Go ahead and answer, if you can.

Mr. IWRY. Sure. We have been taking pains to implement as far as the Treasury Department is involved in implementation the medical savings account provisions in as smooth and efficient a way possible consistent with the statutory provisions, and to that end, Senator, we issued in November a fairly extensive set of questions and answers in as much of a plain English form as the Treasury Department and the Internal Revenue Service can achieve on matters as complex as these to try to help people understand medical savings accounts, what they are, how they work, how one can get one, and that was intended to respond to the questions that we were getting and that I know members were receiving as well as to how one could obtain a medical savings account.

We essentially delivered the message that this is a product that will be coming on the market; it is a private sector product that people can buy and sell without obtaining permission from the Government—there is no license or authorization from the Government that is needed in order to purchase a medical savings account—and that certain kinds of institutions are authorized to sell or establish medical savings accounts in a manner that is somewhat analogous to IRAs.

The feedback we have received since that question and answer notice was issued has been very favorable from the public, from the relevant parties in the market and from people on Capitol Hill and seems to have worked reasonably well in helping to orient people as to what these things are and how to get them.

The other thing we have been doing is to focus on the need to revise tax forms so that the medical savings accounts do get implemented in the way that was intended, including the tax forms that will permit the counting of MSAs in order to implement faithfully the intended limitations that are part of the pilot project. We have worked with the Internal Revenue Service to focus very hard on the need to get all of this done in a timely and accurate manner.

Senator REED. So you feel at this juncture that you are particularly prepared, essentially dealing with the cap, limiting it to the 750,000 beneficiaries or participants, I should say.

Mr. IWRY. The people at IRS have told us that they are in a good position to count and to implement those provisions, and they have taken special steps to be ready to do that in an accurate way, and

we are continuing to remind them of the importance of being in a position to do that.

Senator REED. Let me ask one final question. Last year, there were other health bills that were passed—the Mental Health Parity Act and the Newborn and Mothers Health Protection Act—and I am just wondering if there has been any problem reconciling those pieces of legislation with the portability provisions or the overall provisions of this bill.

Ms. BERG. As we have been mentioning, there are different portions of HIPAA that the different departments have responsibility for that we are all working on. In addition, we have the other two laws, and we are trying to coordinate all of that as we move along so that whatever we do in one area will be consistent with the requirements.

We think that we are doing that now, but some of the regulations and things will be following. It is sort of like a triage. The most immediate problem is the April 1st set of regulations, and then we will continue to move on with the rest of the implementation and further regulations after that.

Senator REED. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Collins?

Senator COLLINS. Mr. Chairman, thank you.

I want to commend the chairman for holding this oversight hearing on what, during my campaign for the Senate, I always referred to as the "Kassebaum-Kennedy" bill. Had Senator Kennedy remained today for this hearing, I was going to call it the "Kennedy-Kassebaum" bill.

This is very important legislation. Since I am new to the Senate, I was not involved in the deliberations on this landmark bill. However, I served in the cabinet in Maine for 5 years in the late eighties and early nineties, and my department proposed legislation at the State level very similar to the legislation that we are talking about today. In fact, we were the first State in the Nation to have guaranteed availability, renewability, protection for people with preexisting conditions and to increase the portability of health insurance.

I want to report to my colleagues that, despite the concerns expressed by some when this legislation was enacted, in Maine, we did not see skyrocketing premiums and we did not see the health insurance market dry up. We can hope that this is an example where, as Maine goes, so goes the Nation, and I do think that the experience at the Federal level will be a similarly positive experience once we get the law fully implemented.

There is a great deal of work, Mr. Chairman, to be done by all concerned to ensure the successful and smooth implementation of this important new law. The real challenge for Federal regulators and States alike will be to implement this landmark statute in a way that provides both protections for individuals and flexibility for employers.

I appreciated the assurances of the witnesses and also appreciate hearing the progress that has been made to date. I have just one question that I want to ask our panel, and it is really a follow-up on a point that was raised by my colleague Senator Enzi. With

three Federal agencies involved in the development, implementation and enforcement of the regulations, and given the important role that the States will still be playing, there is bound to be some confusion on the part of the general public about where they should go if they have a problem or if they believe that their rights under the law have been violated.

If I had gotten a constituent complaint in this area, before I would have referred them to the consumer division which I created in the State of Maine's Bureau of Insurance—but now, to whom should my constituents go first? Where should they seek help or advice if they believe that their rights under the law have been violated?

Ms. BERG. I think the answer to your question is that it is going to depend, and the major thing we can do—and I think we are headed down this road—is enter into cooperative arrangements with the insurance commissioners and others, so that depending on the circumstances of the individual who comes in with a question, we get them to the right place with the answer as quickly as possible. So we will all be working together as part of this overall effort to ensure that we do that.

Now, we already have some model for that in our overlapping responsibilities under ERISA, so we have developed these relationships, and I think that that will serve as a foundation as we go forward.

Mr. IWRY. If I could elaborate on that, Senator Collins, under ERISA and under COBRA as well, there are overlapping jurisdictions as Ms. Berg has said, and in the case of COBRA, which is so closely related to these new group portability provisions, complaints that individuals have, concerns that individuals have that their rights are not being respected, are commonly referred to the Department of Labor and, as I understand it—and my colleague Ms. Berg can elaborate on this—if appropriate, the Department of Labor often then goes to the employer if the employer is the party who apparently is at fault. The fact that Treasury and the Internal Revenue Service share jurisdiction with the Department of Labor in the COBRA area has not, I think, proven to be a real problem. Typically, the initiatives that are taken to try to get compliance, as Mr. Vladeck said, as opposed to enforcement for enforcement's sake or sanctions for sanctions' sake, the effort to get people to comply, which is often a matter of just educating them as to what the rules are and what they need to do, seems to work pretty well that way.

The sanctions that apply, for example, under the Tax Code, the excise taxes, appear to perform a deterrent function but not to complicate the issue of where to go for help in the case of an individual.

Senator COLLINS. Do you have anything to add, Mr. Vladeck?

Mr. VLADECK. No. I think my colleagues have covered it. Again, we are learning as we go, but I think there is a substantial amount of good faith involved, and we have actually been pleasantly surprised by how well this is evolving and we will be able to switch back and forth, I think, pretty quickly.

Senator COLLINS. The only caution I would give the panel is, having headed a regulatory agency in a State government, I know how extremely frustrating it is for the average citizen, for the

consumer, to call and get bounced from agency to agency or department to department. So I would urge you to think about the issue from the perspective of the consumer.

While I am also concerned about small businesses and employers, quite frankly, they are probably going to be all right because they are going to be relying on advice from their insurers. It is really the consumer that I am concerned about as far as making sure that the process is not intimidating if they do run into a problem and that they do not get bounced from agency to agency.

So thank you very much, and thank you, Mr. Chairman.

The CHAIRMAN. Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman, and I want to thank the panel for excellent information this morning. We appreciate the work you are doing on implementing this.

I just want to explore a couple of areas, one of which touches on what Senator Collins just talked about, and that is the consumers and their information. There is a lot of misinformation out there right now about what this bill does and how it is being implemented. You talked a little bit about the booklet that you have, but if you could tell us a little more about what you are doing to educate people out there about what this bill does, I would appreciate it.

Ms. BERG. Yes. Again, we are trying to distribute the booklet as broadly as we can because it does answer the basic questions. And I will say that we would be very pleased to deliver copies to any of your offices if you are able to help us with that effort as well. We are giving speeches in any venue that we have available—again, as I mentioned, particularly with the employer community because the way much of this information is conveyed to individuals is through their employers where they have the health plan.

We are working with groups like the International Foundation, again, doing outreach programs. And we anticipate as different events occur—for instance, the publication of the regulations in April—that at those periods of time, we will do major press presses, if you will, to try to get this into advice columns, financial columns, anywhere we think consumers may go to try to get this information.

Senator MURRAY. OK, great. I think it is really important that we put that effort out there, and thank you for doing that, so that we have good information and not misinformation. That leads to fewer problems later, so I appreciate it.

The other area I just want to touch on quickly was brought up by Senator Reed as well, and that is the criminalization of asset divestiture. I am hearing from a lot of senior citizens who are very concerned about this. It was a nice punt to just ask us to repeal the law, and I can hear what you are saying, but if that does not occur, is there a way to clearly define some of the unknowns in this, or do you just see that as impossible?

Mr. VLADECK. Senator, we believe that—and again, we are trying to figure out the appropriate way in which to do these things because the chairman asked us, I think appropriately, whether we needed any changes in the basic provisions of the law at this stage, and we believe we do not—we believe that there needs to be a vehicle sometime during the course of this session of Congress to sig-

nificantly change or repeal that particular provision of the criminalization of asset transfers.

It is always somewhat awkward to have to be put in the position of saying that we will or will not enforce a piece of statute that is on the books, but I think the experience with transfer of asset legislation generally over many years in the Medicaid program has been that the States have used the authority provided by the Federal law very differentially. We have encouraged them to use the authority that they are permitted to under preexisting authorities, but we have not taken actions against States one way or another in terms of how they have chosen to act with these issues.

We will certainly not be pressing the States to enforce this particular provision at the moment, and again I do think our preference, given the identification of the appropriate mechanism in this session, would be to change that part of the law.

Senator MURRAY. Thank you. I have a question for you, then. There is a concern out there that we get Medicaid dollars to low-income seniors and children and that we do not have transfers of assets, but is there a better way to do this rather than putting seniors in jail?

Mr. VLADECK. Well, I think, Senator—and I do not mean to put you off at all—I am going to say that I would appreciate the opportunity at some point to have a much fuller discussion of this in whatever the appropriate venue would be because it is a very important and very complicated issue.

I think, however, as best we can tell—and there is some recent research that we have supported—that the public perception of the magnitude of this problem and the actual magnitude of this problem may be at significant variance.

We have one of these instances or areas in which a few people doing something egregious can create a perception of a very widespread problem that might, on the other hand, provide an enormous source of additional public funding or something of that sort.

There has been a fair amount of work on this over many years. It is a very troublesome problem. We think some States—I single them out at some risk, Senator, but I think the State of Oregon has probably been the most effective and visible in taking some good steps in this regard. So that within the confines of the pre-1996 legislation, there are a number of things States can do, and we encourage States to do them. But I think it is important not to exaggerate the importance of this phenomenon in the overall picture.

Senator MURRAY. I appreciate that, Mr. Chairman. I hope we can explore that because I think we do need a picture of the real truth of this and the reality of it and the magnitude, as you suggest, but also how we can cope with it without using a sledgehammer to kill an ant.

The CHAIRMAN. That is an excellent point.

Senator Wellstone?

Senator WELLSTONE. Thank you, Mr. Chairman, and I apologize to the panelists for being late.

Let me just ask one question which actually builds on Senator Collins' point and the question that Senator Murray had. I remember a couple of years ago when we were having the rescission battle, and I got involved in a battle on one particular program, which

was the insurance counseling and assistance program, which is sort of interesting, and it ended up that indeed it was not eliminated. I think there was a proposal to eliminate it, and I remember making the argument about $10 million or something nationally, because it relies so much on volunteers and has really been just enormously helpful to senior citizens on Medigap and making sure people do not get ripped off.

I know Gail Shearer from Consumers Union is going to raise this question also, but what about extending onto that program where you have something already in place which has been enormously successful—might that not be at least in part an answer to the question of how we can make sure that consumers, ordinary citizens, really have the information they need and have some protection?

Mr. VLADECK. Senator, if I may—and we very much appreciate your support of that program over the years, and it is very much alive, and indeed, in the President's budget bill, you will see provisions to strengthen it and expand it considerably—I believe it might very well be a good model for an additional program. The insurance counseling programs that have grown up under the Medicare statute have become quite specialized in their expertise about the particular insurance and health care needs of Medicare beneficiaries. They are extraordinarily useful, and we need to expand and strengthen them. Rather than expand their role, I would think it might make more sense to use that model or that analogy to see whether, again, working through the States as we have on the Medicare insurance counseling, there is another illustration of where, with a nominal amount of Federal dollars, we can mobilize volunteers and others to help consumers throughout the country.

Senator WELLSTONE. Well, maybe, Mr. Vladeck and other panelists, another way this might happen, but it sort of depends on what happens here, Mr. Chairman, legislatively—and I know the chair has been interested in this—if we end up passing some legislation—I have introduced a bill, and I am sure others will, too, and I am sure all of us will work together on both sides of the aisle—along the lines of patient protection, not just targeted at managed care but at all the plans, and basically part of that is to create an office at the State level of consumer information, assistance, counseling or whatever, that office might be the model for doing this. I know that in Minnesota, there are many efforts at the State level to do just that right now, and of course, one problem is that if it is not national, about 50 percent of people who are covered by self-insured plans just are not going to be covered—but we might be able to do it that way, because I think there is getting to be more and more focus on consumers and where consumers fit in and how you can get the information to consumers, and not doing it from Washington but doing it at the State and local level, and not doing it just with Government employees—and I honor the work that people in the public sector do—but relying on a lot of volunteers. That might be another way of doing it.

Mr. VLADECK. Senator, as was I think implicit in Senator Collins' comment, this is again one of those instances in which a number of pioneering States are already out front of us where the Federal Government might learn from what some of them are doing as a

way of making that kind of model more broadly available to the States. We would be happy to work with you further on exploring that idea.

Senator WELLSTONE. Good.

Thank you, Mr. Chairman.

The CHAIRMAN. I want to thank all of you. You have been very patient, and you have given very articulate answers, and I personally come away feeling rewarded that things are going pretty well. You are doing a good job; just keep it up.

Thank you very much.

Mr. VLADECK. Thank you very much, Mr. Chairman.

Ms. BERG. Thank you.

Mr. IWRY. Thank you, Mr. Chairman.

The CHAIRMAN. For the next panel and for members of the committee, we will go to the 5-minute rule in order to make sure we can conclude, by lunchtime.

The second panel today includes individuals who have worked closely with the States. They will discuss State implementation of group to individual portability requirements. This is a difficult area of the law, and we will listen intently to our witnesses.

Ms. Joy Wilson is Federal affairs counsel and director of the health committee at the National Conference of State Legislatures. In addition to her duties at NCSL, Ms. Wilson has worked on the Pepper Commission, a bipartisan commission on comprehensive health care which many of us recall. It is nice to have you here, Ms. Wilson.

Josephine Musser currently serves as commissioner of insurance for the State of Wisconsin. Ms. Musser also sits on the Group Insurance Board, the Insurance Securities Fund Board, the Health Insurance Risk-Sharing Plan Board of Governors, and the Small Employer Insurance Board. What do you do in your spare time?

Ms. MUSSER. I am president of the NAIC.

The CHAIRMAN. President of the NAIC. That is good. Ms. Musser has testified before the Labor Committee in the past, and I look forward to hearing you testify again.

Chris Petersen serves as vice president of the State Affairs/Legal Department of the Health Insurance Association of America. Mr. Petersen also served on the National Association of Insurance Commissioners' Industry Working Group on Access, which drafted NAIC's small employer market reform model act. Welcome, Mr. Petersen.

And Susan Nestor is executive director of legislative policy in the Office of Policy and Representation for the BlueCross and BlueShield Association. Prior to joining the Association, Ms. Nestor also served as a health care policy advisor to the Senate Finance Committee. Welcome back to the Hill, Ms. Nestor.

All right, Joy, if you will please proceed, we will use the lights. Try to keep it within 5 minutes, and if you go over a little bit, that is all right; but I want to make sure we all have an opportunity to question and that things go expeditiously.

Please proceed.

STATEMENTS OF JOY JOHNSON WILSON, FEDERAL AFFAIRS COUNSEL AND DIRECTOR, HEALTH COMMITTEE, NATIONAL CONFERENCE OF STATE LEGISLATURES, WASHINGTON, DC; JOSEPHINE MUSSER, MADISON, WI, CHAIR, SPECIAL COMMITTEE ON HEALTH INSURANCE, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; CHRIS PETERSEN, VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC; AND SUSAN E. NESTOR, EXECUTIVE DIRECTOR OF LEGISLATIVE POLICY, BLUECROSS AND BLUESHIELD ASSOCIATION, WASHINGTON, DC

Ms. WILSON. Thank you, Mr. Chairman.

I would like to convey the regrets of Representative David Ennis, who had intended to be here but took ill, so I am trying to do my best to be his replacement today.

It is a pleasure to be here to talk about implementation of the Kennedy-Kassebaum bill. We are proud to have been a part of making that happen. We enjoyed working with those of you on the panel who were here, and we are looking forward to continuing to work with you on the implementation phase of this legislation.

One of the things that I would like to stress is that every State is going to have to take some action to come into compliance with the law. It has turned out to be a little bit more complicated than many of my members had anticipated, but they are working very hard to bring their State insurance codes into compliance with the law.

Of particular concern are those States that have short legislative sessions this year. Their primary concern is that when they move forward, and they make the good faith effort in the case where they are out of compliance with the rules that come down April 1st after they have left session, we do have some States that will not be in session next year, so this means that in order for them to come into compliance, they will have to give over some of their responsibilities to the executive branch or to the regulatory agency, and they find that somewhat troublesome.

One of the things that would be very helpful is if we could get—in cases where they have a question of interpretation of the law, if we could get some heads up on the leanings of some of these agencies, that would be very helpful. There are some key questions on interpretation that, if we can get a clarification, I think some of those States would find it helpful, and we are looking forward to working with HCFA on that issue.

We do have a statutory concern. It only affects the State of Kentucky. It is one of those things that we run into from time to time. Kentucky does not have a regularly scheduled session for 1997. However, they did have a special session in December of last year where they only dealt with workers' comp issues.

A strict reading of the statute which does not differentiate between a regular session and a meeting would suggest that perhaps the extra time that would have been extended to them under the statute for States that did not meet for the time period after the law was enacted and for a 12-month period thereafter, it would seem that their having met in December would—they met. So we are asking for a broader interpretation to allow Kentucky some ad-

ditional time given that they are not having a regular session this year.

The other issues that we want to briefly cover are some of our concerns about the guidance that HCFA put out regarding the individual market reforms. Clearly, the 30-day submission date is going to be very difficult for a number of States, and we know that that is advisory and not a mandate, but we suggest that calling up all the States that do not submit information is probably not a good use of time, and we would much prefer if they could move up that April 1 date and get some of the interpretation of the law done for those States, that would be more helpful.

In terms of the documentation, we understand from hearing the administration witness that perhaps we went through that with a little too fine-toothed a comb, but our feeling was that some of the documentation that they were suggesting States would need on the individual market reforms was more than could be done in the time frame that we have to work within. And going back to the statute, where there is a presumption of acceptability, it would be our hope that a State that certifies that they are meeting the requirements of the law, that there be an assumption that they are doing so and that the Secretary measure against the minimum standards that are set in the law.

Finally, we are working very closely with HHS. We are scheduled to have a briefing this week that is supposed to be in depth and comprehensive, and we will be filing some more specific concerns with them and trying to get some of that advice on some of the key issues where States are saying they need some additional assistance. And having heard what they said earlier today, I think that we are going to be successful with that and that States will be able to successfully implement.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Ennis may be found in the appendix.]

The CHAIRMAN. Ms. Musser?

Ms. MUSSER. Thank you and good morning, Mr. Chairman and members of the committee.

My name is Josephine Musser. I am the president of the National Association of Insurance Commissioners and the chair of the NAIC's Special Committee on Health Insurance, which is comprised of 42 of our member States. I am also the commissioner of insurance in the State of Wisconsin, and on behalf of Governor Thompson and the great State of Wisconsin, as well as the entirety of the NAIC membership, I very much appreciate the opportunity to address you this morning on the subject of health insurance portability and accountability.

In crafting HIPAA, Members of Congress recognized that the States have paved the way in the area of insurance reform, and as a result they granted significant flexibility for the States in the implementation of HIPAA. We genuinely appreciate this recognition and thank you for your continued interest in monitoring State implementation and coordination with the Federal agencies.

Soon, beneficiaries of self-funded plans governed by ERISA will be afforded some of the very same protections already available to

those covered by insured plans. Today I am pleased to bring you a progress report on the States' insurance departments' activities relating to the implementation of HIPAA.

The flexibility provided by HIPAA presents the States with many important policy questions. The answers to these questions will largely depend on the actions of State legislatures and Governors. The information that I am going to provide to you today is based on the State insurance departments' knowledge to date of the direction their States might take and is certainly subject to change based on gubernatorial and legislative decisions.

Since passage of the new law, the NAIC has contacted every State insurance department to survey and obtain detailed information about each State's plan for implementation. To assist the States in implementation decisions, the NAIC committee is finalizing an implementation manual which we expect to have completed by the end of this month. The States now have draft copies of this manual.

The manual seeks to provide a broad understanding of the Federal statute and identifies suggested revisions to the seven NAIC model acts that are significantly affected by HIPAA.

The process of drafting these revisions is an open process. The NAIC seeks and receives extensive comment from consumer groups, the insurance industry, Federal agencies and all other interested parties. As a result of the NAIC's survey of State insurance departments, we have learned the following information. Thirty-five insurance departments report that their States will probably adopt an alternative mechanism to the Federal standards. Nineteen of those most likely will use risk pools. The other 16 may use another kind of alternative mechanism such as guarantee issue. Nine insurance departments responded that their States would probably adopt legislation enabling the State to enforce Federal standards. Six insurance departments reported that their States have not yet made a decision about their approach.

In the small group market, 19 States have already defined the size of small group consistent with HIPAA, but some of these States will make changes to their definitions for other reasons. Approximately 10 States will have to expand significantly the size of the group as defined in "small group"—as will Wisconsin. At least one State insurance department may recommend reducing the size of its State definition of "small group." Some insurance departments indicated their State will not have to change their definitions of "small group" for any reason.

With respect to rating, 22 insurance departments indicated they did not intend at this time to recommend modifying rating provisions, while 20 departments indicated that they might or would make such a recommendation.

In the large group market, most States plan to make only the changes to their State laws that are minimally required by HIPAA.

The written testimony that we submit today also summarizes the responses and recommendations of the State insurance departments concerning their State plans regarding long-term care insurance policies and medical savings accounts. With respect to my own State of Wisconsin, Governor Thompson understands the importance of HIPAA and HIPAA requirements for the citizens of Wis-

consin; in fact, he will provide details regarding his proposals relating to HIPAA in his budget message to the Wisconsin legislature tomorrow. It is very important that he understood and included in the budget bill the HIPAA provisions in order to accomplish timely passage and implementation.

The NAIC committee is currently drafting a letter to the three Federal agencies regarding interim final regulations under HIPAA. In this letter, we will offer our technical expertise as the Nation's regulators of health insurance. With over 125 years of experience in the business of regulating insurance, the States have a proven record of accomplishment in protecting consumers and providing a viable marketplace.

With respect to the guidance already issued by HHS, the NAIC committee submitted a letter this week to Mr. Vladeck at HCFA in response to the January 13th notice in the Federal Register. I believe you have a copy of our letter. In it, we stress our understanding of a strong statutory presumption in favor of State proposals as long as they meet the statutory criteria. Our understanding appears to differ from the application and approval process outlined in the Federal Register notice.

The NAIC will continue to communicate with the Federal agencies regarding the proposed guidelines and regulations, and we hope that the agencies will continue to receive our comments into consideration.

I thank you for the opportunity to testify before you today and later will be happy to answer any questions.

The CHAIRMAN. Thank you very much, Ms. Musser.

[The prepared statement of Ms. Musser may be found in the appendix.]

The CHAIRMAN. Mr. Petersen?

Mr. PETERSEN. Thank you, Mr. Chairman, members of the committee. I am Chris Petersen of the Health Insurance Association of America.

The HIAA welcomes this opportunity to discuss this important statute. We have submitted a detailed statement to the committee which I will summarize today.

HIPAA was a major and in many ways unprecedented action in the health benefits field. We applaud the work of your committee and staff in developing this legislation.

Subsequent to the enactment of HIPAA, HIAA has offered our support and comments to the three regulatory agencies responsible for administration of the law. We are impressed with the dedication and the efforts with which these agencies have approached their responsibilities.

HIAA has also worked closely with the NAIC whose staff has put in countless hours in advising the individual State regulators concerning the implications of this legislation.

HIAA shares in what we believe are the common goals of the Congress, State legislators, the NAIC and the insurance community. These goals are: the appropriate and efficient implementation of the Federal law, clarity in the regulations so that all entities providing health benefits plans are playing under the same rules, and continued regulation and enforcement of insurance at the State level.

In many cases, changes in existing State laws are necessary for the States to satisfy the Federal requirements. The need for change exists in every State. Many of these changes will be technical in nature but nonetheless each State must take legislative action.

One particularly critical area regarding State legislative changes involves the individual insurance market where, in order for State enforcement to apply, State Governors must certify by April 1 of this year their intention to adopt an "acceptable alternative mechanism" to provide for portability in the individual market. We believe it is in the public interest that the States assume this regulatory responsibility. Our position is that States must be granted maximum flexibility in ensuring compliance in the individual market. And I am quite pleased that almost every other witness so far has the used the word "flexibility" in their statement.

Even though HIPAA's enforcement requirement is permissive, the intent is clear that in the case of health insurance, the exercise of Federal authority is itself limited to instances where, with respect to single or multiple provisions of the Act, a State has substantially failed in its enforcement.

In advising their enforcement strategy, the States will determine what cost-effective mechanism will achieve the necessary substantial enforcement. The Act allows each State the flexibility to adopt whatever sanction or remedy it believes necessary to carry out the provisions of the legislation.

The Act also imposes new certification requirements, and HIAA has a number of concerns related to these requirements, concerns pertaining both to the issuance of certificates and to the receipt of certificates when individuals exercise their portability rights.

It is important that there be a clear division of responsibility for the issuance of certificates and that the responsibility not rest simultaneously with the plan, the employer and the insurer.

Currently, in large employer coverage, the employer maintains employment records, including information about which coverage option an employee has selected and whether it is employee or family coverage. Conversely, in small employer groups, generally, it is the insurer that maintains records of covered individuals. In the large employer situation, it would be appropriate for regulations to place the certification responsibility with the employer. On the other hand, this responsibility should be placed with insurers in the small employer market.

We also believe that regulations should require certification based upon uniform data elements and that regulations should include a model certification form to be used on a voluntary basis. To ensure that entities issuing certifications have the necessary information, an underlying assumption should be that individuals exercising rights under the Act are responsible to provide employees and insurers with information and verification regarding the coverage of employees and dependents.

HIPAA also sets forth requirements pertaining to the guaranteed renewability of individual major medical coverage. Because the law is silent with respect to cases where a person covered under an individual health insurance policy becomes eligible for Medicare by reason of age, we are concerned about a possible regulatory interpretation that insurers must renew such coverage for Medicare

beneficiaries. It is our view that HIPAA was silent on this issue simply because there is no individual insurance market in the over-age-65 population. Carriers may not sell major medical coverage to this population group and thus should not be required to renew the coverage.

Prior to the enactment of HIPAA, the NAIC's individual model act provided for an exception to guarantee renewability in the case of Medicare eligibility due to age. State regulation has always held that termination of coverage when an individual becomes eligible for Medicare was an acceptable policy contract provision of an individual major medical policy.

Congress has previously determined that for persons age 65 and older, health insurance coverage would be provided through Medicare and that private coverage would be supplementary. It is important as a matter of public policy that Medicare beneficiaries not pay premiums for private medical health insurance coverage that truly duplicates Medicare.

As indicated above, these and other issues have been placed before the agencies with regulatory responsibility, and we are hopeful that our positions will be given due consideration. HIAA appreciates the opportunity to present this information to the committee.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Petersen may be found in the appendix.]

The CHAIRMAN. Ms. Nestor?

Ms. NESTOR. Thank you. I am Susan Nestor, and I am executive director of policy for the Blue Cross and Blue Shield Association. Our association represents the 59 independent Blue Cross and Blue Shield plans across the United States.

I want to thank you for the opportunity to testify today on behalf of the association and compliment the Departments of Health and Human Services, Labor and Treasury for all the hard work that they have been doing to develop the regulations.

I want to answer your questions first about the process, how we have been involved in that, and then, second, highlight a couple of key issues to our plans.

As it relates to the process, we took our leadership role very seriously in Blue Cross and Blue Shield. Our plans are in every State. We believe that consumers are going to ask our plans questions about the bill. States have asked us for assistance. And we decided after the bill was enacted to go around the country. We held 10 regional meetings from Seattle to Los Angeles to Pittsburgh to Atlanta, met with over 800 of our employees at our plans. We had special broker and agent meetings to explain the law and to ask questions that we could come back to Congress and to the departments to give you input on the regulations and what, practically, our plans thought would be problems.

I went personally on those trips, spoke with over 800 of our employees and agents, and so what I would like to talk about are some of the key issues that they thought were essential.

We have also had 12 all-plan conference calls where we have gotten more details with them, and we have met six times with the

Department to give them input and then follow up with written comments on each provision of the bill.

As relates to issues, you have detailed testimony where we actually lay out issues in a number of areas, but I really want to focus on three. The first is certificates of coverage. We believe this is an essential part of making sure that people are given the rights that you gave them in the law. However, we believe that automatic issuance of certificates has some unanticipated consequences. We are concerned that the consumers who really need those certificates may not get those if in fact we are automatically issuing in circumstances where an individual does not need it.

Let me give you an example. If I am in a health plan for an employer, my annual enrollment, I change from an HMO to a PPO option. I stay with the same plan, I stay with the same employer. Some have said that the law requires an automatic certificate in that case. We do not believe that that was really what you intended, and in fact what we would recommend is that issuance of certificates be upon request. When any consumer needs that because he or she is facing a preexisting condition requirement, they should on a very timely basis get that certificate. But we would ask that you clarify that it is not automatic in every case, because I could give you some other examples of when we think it is just not needed and will be unnecessary.

Second——

The CHAIRMAN. Could that be done by regulation, or do you believe we will have to change the law?

Ms. NESTOR. I will say the Department has said they do not feel they have a lot of flexibility on this issue. We believe in our interpretation of the law that they do, but the reason I wanted to raise it here is because there may be a need for a technical correction to the law.

The CHAIRMAN. OK.

Ms. NESTOR. Second, I would echo what Chris Petersen identified. It is very important that either plans or employers are responsible for these certificates; otherwise you are going to have a duplicative process.

Third, we would also ask that in regulation, we are not required to have information on certificates that we have no way of knowing or collecting. Our plans tell us they do not collect information on dependents. They do not, for example, collect date of hire; an employer keeps that information. So information like waiting periods is just not something that our plans collect or have knowledge of. We have provided a model certificate to the departments and suggested what they might include on the certificate.

The second issue, I also would reiterate what Chris Petersen mentioned about guaranteed renewability when someone becomes eligible for Medicare. We do not believe the law intended that there is guaranteed renewability of private plans once someone is eligible for the Medicare program. We believe that that needs to be clarified and can be in regulation.

Third, I want to mention—and I know it was not the specific purpose of today's hearing, but I know it is of interest to this committee—in the administrative simplification provisions, the requirement is that if someone asks for a standard transaction, a plan

must comply and do a standard electronic transaction. We are supportive of that. We are hearing that there is some belief in the departments that in fact it is a mandate on health plans in every circumstance.

We are concerned about that. We have inter-plan systems so that if a person with a Blue Cross card in Oregon goes to Florida, it is seamless to that consumer. Those are our own systems. We believe the Department is interpreting that we would have to follow standard transactions, and we do not believe that that was the intent of the law, so we would like that to be clarified in regulation.

Thank you for the opportunity to testify.

[The prepared statement of Ms. Nestor may be found in the appendix.]

The CHAIRMAN. Thank you all for your excellent testimony. I know we are going to have some problems as we go along, and that is why I would appreciate it, Ms. Nestor, if you could make us aware of instances where you feel a statutory change is needed and instances where you feel a regulatory change would suffice. We will work with the regulators and help you out in that regard.

Ms. NESTOR. That is great. Thank you.

The CHAIRMAN. Ms. Wilson, in your testimony, you indicated that the effective dates for many of the provisions of HIPAA are unrealistic, in light of the work to be done in some of the legislatures. How much more time do you feel is needed at the State level? I suppose that depends on the State and the problems that you indicated. And I would ask that the NCSL keep the committee informed regarding those problems. You have mentioned some, but if there are others, please let us know.

Ms. WILSON. We will do that, and we are tracking the States as they put in their legislation so that we are aware when the bills go in and how they progress. As they are being introduced is when we start hearing from the States, so I think we will have some idea of what the problems are as they come along.

The CHAIRMAN. Ms. Musser, thank you for not mentioning the Super Bowl.

Ms. MUSSER. I almost did. [Laughter.]

The CHAIRMAN. When Senator Kennedy left, it diminished in importance; but nevertheless, I appreciate that.

In your testimony, you indicated that seven States are still undecided regarding their approach for complying with the Act's requirements for the individual insurance market. Do you feel it is likely that there are going to be States that allow the Federal Government to enforce the law relating to the individual market?

Ms. MUSSER. Well, we do not have specific information on it, so this is pure speculation on my part. My understanding from my colleagues is that that is unlikely. I think that the States will be actively either adopting the Federal standards or choosing an alternative mechanism.

I do not have the specifics on the six or seven States that are undecided at this time. The survey asked the standard questions, and they did not have any answer for it at this point, either because of legislative timing or other issues of research and analysis and drafting.

The CHAIRMAN. You mentioned that many States are amending the definition of what a small employer is. Do you feel it would be beneficial to have a national definition?

Ms. MUSSER. I think that what HIPAA did, very importantly, was to create the floor, the 2 to 50, and then allow the States to go beyond that. There are some States that are 2 to 60, there are States that are 2 to 75, there are States that are 2 to no upper limit on some of their current portability provisions in the insured market, and I think it is important and generous to allow that to remain in place, and by creating the floor, we have the minimum national definition but not necessarily the only definition.

The CHAIRMAN. Mr. Petersen, in your testimony, you discussed at length the States' acceptable alternative mechanism and the need for the Federal agency to exercise flexibility to review process provisions. Do you have any reason to doubt that Federal agencies will give that kind of flexibility?

Mr. PETERSEN. From our discussions with them, I think they will be exercising that sort of flexibility. States will not be adopting verbatim, for instance, the NAIC models. We have identified what we think are the key elements of those models, and if a State meets those key elements, we believe they should be an acceptable alternative mechanism, and I think we are encouraged that HCFA has understood that and is going to be accommodating to the States.

The CHAIRMAN. Susan, you made a valid point as to the necessity for all persons to be issued a certificate of coverage; in addition, the health insurance issuer would provide the certificate, not the employer. Can you foresee any circumstances where it should be the employer instead?

Ms. NESTOR. Yes, Senator. We would recommend that it be one or the other, and I know that Chris Petersen suggested a couple of examples when it might be the employer. What we are requesting is that it not be duplicative, that a decision be made as to whether it is the insurer or the employer in the regulations, so that we will not have a duplicative situation.

The CHAIRMAN. You mentioned the blur in distinction between group coverage and individual coverage, where coverage is provided through associations. Can you elaborate on this, and is there a definitional clarity that is needed?

Ms. NESTOR. What we suggested relating to association coverage is that when someone purchases their insurance through an association as an individual, for purposes of creditable coverage, that would be that you would count them as collective individual coverage. If they purchased that through a group, then it would be counted as creditable coverage in a group. People tend to do one or the other, and we just thought that that should be clarified.

The CHAIRMAN. Thank you.

Senator Enzi?

Senator ENZI. Thank you, Mr. Chairman, and I want to congratulate you, too, on the complete span of witnesses today who are involved and participating in this process. That is very helpful for giving me an idea of what is happening with the law.

As I have mentioned before, I have had the honor of serving in the Wyoming State legislature for 10 years, and I have been mayor of a town that more than doubled in size, and I have been in small

business at the same time, so I am bringing that perspective to these regulations.

I do think the purpose of HIPAA is well-intended and that it will help our thousands of employees who right now are locked into their current jobs due to the lack of insurance portability. It is important that there be a spirit of cooperation between the Federal Government and the State Government to make sure that this administrative process takes place as easily as possible.

I do not want to sugarcoat the truth, though—HIPAA is a Federal mandate, and it intrudes into the territory that has been a traditional domain of the States and the insurers. The law contains provisions that establish uniformity among States in regard to health insurance portability, accessibility and renewability.

I believe in work to see that States have and must continue to have the ability to regulate the health insurance market. This law should not be used as a vehicle to do otherwise. Until last month, I was a member of the National Conference of State Legislators, so I appreciate your involvement, Ms. Wilson, in this process and want to ask you specifically some questions.

Ms. WILSON. Thank you.

Senator ENZI. Do you think that the law has provided States with enough flexibility to comply?

Ms. WILSON. I think we will be able to comply as long as we can work with the Department on the interpretation to make sure the legislators get the interpretation in time to enact the laws.

I think the threat that the legislators feel is that they will have to turn over their authority to the regulatory agency or to the Governor in the absence of them being in session. That is their concern. So we want to work with the Department to make sure that they have the guidance they need to do what they need to do while they are in session.

Senator ENZI. You commented earlier on the time frame for complying with the law. Do you really feel there is adequate time for the States to put their insurance process into this piece of legislation?

Ms. WILSON. I think it will be done in stages, that initially, they will at least be able to bring their codes into compliance so they will not have Federal regulation going on in their States, and I think that over time there will be some additional legislation that will come out of this, and it will evolve like all insurance legislation does at the State level.

On the individual market reforms in particular, I think there is probably inadequate time for States to do all that they might want to do in that area, and certainly I think that that is an area where you will see some additional actions taken over time.

Senator ENZI. Under the Act, States are not required to enact or enforce any additional standards that are not included in the law. Do you anticipate any pressure from the Federal agencies, or are you noting any pressure from the Federal agencies to apply a higher standard?

Ms. WILSON. No, I have not seen that. I think the Federal agencies are basically urging us to come into compliance. I do not think that they want to regulate these laws in the States any more than

we want them to. So I think there is a mutual benefit to us working very closely with them so that we can come into compliance.

Senator ENZI. Thank you. As a final question, are you hearing from the States of any additional financial burdens that they are having to take on as a result of this law?

Ms. WILSON. Not yet. Right now, most of what I am hearing are interpretation of the law questions, questions about timing and the what if we enact something, and it is not quite right. One of the big questions that I have been asked is would the Federal Government try to make us have a special session. That question is raised in the guidance and is significant for, as you know, the members of NCSL, and to the extent that they make a good faith effort and it does not meet standard after April 1st, and they are out of session and not scheduled to go back in session until after January 1 of 1998, the question is what then.

Senator ENZI. I really appreciate that because Wyoming feels very strongly that they should not have any special sessions. They try to utilize their 20 days 1 year and their 40 days the next year to the best of their ability and even save a couple days so they can override gubernatorial veto if they have to.

For any of the rest of the panelists, do you think employees will know whom to turn to in case of abuse by an insurer or an employer? Do you think that that is taken care of in this law?

Ms. MUSSER. I think I can best address that. It is very important that the consumers understand to whom to turn, and if you use the self-funded analogy just in the health market today, we have not seen that consumers are clear about where to turn. When we testified earlier on the development of this bill, we very much endorsed the concept of the Federal Government acting in the area of ERISA because the States have no authority there.

Of all the health-related complaints we receive in our insurance department, nearly half are from self-funded employees who do not know that they are in a self-funded plan. I think that that is directly analogous to the situations we may encounter here.

There is a pilot project going on with the State of Oklahoma. There may be other ways in which we can interact with Federal agencies on the State level so that we can assist the consumer. We are doing everything in our power to educate the consumers where to turn.

Senator ENZI. Thank you.

Mr. PETERSEN. Senator, I think the confusion that I see among insurers and policymakers who are familiar with this issue would have to lead us to believe that consumers will be very confused. I think a great deal of education must still occur. Typically, I think Commissioner Musser is right; it is going to be the State insurance department that is first going to hear about these. I think the Oklahoma experiment is an interesting one because people do generally seek out local solutions and local answers first.

We have found that people are very aware of the statute through our polling; it has very high public awareness—but I think the actual rights and protection will be a lot of confusion, and I think a very serious effort must be undertaken to educate people of their rights and responsibilities.

Ms. NESTOR. I would just add that one of the reasons why we went out to all of our plans was to make sure they were very aware of what the law said, so they had plenty of opportunity to work with their States, to work with their consumers and enrollees, explaining the law. Our plans are often viewed as a resource in a State, and I know that many of them now have taken a leadership role and are holding meetings in their States to help explain what is in the law. So we have been trying to act on that.

Senator ENZI. Thank you, Mr. Chairman.

The CHAIRMAN. Do you have any other questions you would like to ask?

Senator ENZI. I do have one more if I could, Mr. Chairman.

The CHAIRMAN. Yes. Please go ahead.

Senator ENZI. I am also interested in the communication between States, the Federal departments and insurers. We have a lot of agencies involved in this. How has the communication been, and how can it be improved? If you were rating the agencies for their communication with you on this process on a one-to-ten basis, with ten being the highest, how would you rate the communication that you have had from the Federal agencies, and are there any ways to improve that?

Mr. Nestor. I will start. I think they have been doing an excellent job in what is a very difficult and complicated task, and we appreciate having had so many opportunities to talk to them and to provide input.

It certainly would be nice to know when we are sitting in a meeting whether they agree with us or not, but I certainly understand that they have others with whom they are talking about this issues. But certainly in terms of our ability to have input, we have had that, and we are looking forward now to the exchange to find out where they have settled on some very important issues, and the earlier we know that, certainly, the better.

Mr. PETERSEN. I would say from HIAA's perspective as well that I think we also wish sometimes they would answer questions. I think primarily they are listening to us because of the constraints placed on them by Federal law, but they have been very open to listening to our suggestions; they allow us to help set the agendas for the meetings when we go in so we can discuss and place some of the issues that we think are important on the table, and there has been a real good dialogue back and forth.

Ms. MUSSER. I think that what is important to note is that we have a mutual goal with the Federal agencies from a State regulatory perspective, and that is for the States to succeed, and that has been very evident in all of our dealings with the three agencies that were represented earlier.

We have had numerous meetings with some, we are beginning meetings with other agencies because of the significance or timeliness of certain issues and regulations. So the process varies a bit, but the communications have been excellent. There have been attendees of the agencies at our national meetings, with hundreds of people in attendance. NCSL and NAIC had an all-day workshop just last Friday to help State legislators produce a document to distribute to State legislators on some of the important issues and

questions State legislators ought to be asking, and some of the technical side from the NAIC.

I think we all have a mutual goal—we want the States to succeed—and everybody is working very much on that effort.

Senator ENZI. Thank you.

Ms. WILSON. I would agree, and I must say that HCFA has been as helpful as they can be, and we are hoping that when they meet with our legislative leaders next month, if they are leaning in one way or another, they might give us a hint or two; that would be very helpful.

We are trying to provide forums for some open discussion, and hopefully for those States that just have a few fine-tuning things to do, we might be able to help them along. So we are hopeful that we are going to be able to make every State a success.

Senator ENZI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, and thank you for your excellent questions.

Senator McConnell has some questions that he would like to ask this panel. He could not be here today, so he has submitted them, and he would like you to submit your answers in writing. Those responses should come to the committee, and we will make sure that Senator McConnell receives your responses.

[Response to questions of Senator McConnell were not received by press at time.]

The CHAIRMAN. I want to tell you how important it is that you keep in communication with us. We will especially be concerned about areas where the States will have difficulties complying because of their schedules; but also from the industry's perspective, we want to be able to keep abreast of any problems so that if we do have to make technical changes, we can do that expeditiously.

You are the ones who, we expect, will protect us from ourselves, and we look forward to working with you again.

Thank you very much.

I will now call forward our third and final panel. Terry Humo is a senior research consultant and attorney with Sedgwick Noble Lowndes, an employee benefits consulting firm headquartered in Memphis, TN. Mr. Humo is responsible for advising a wide range of clients on legislative and regulatory issues related to health plans under ERISA. He also currently chairs the APPWP task force on implementation of the Health Insurance Portability and Accountability Act.

We also welcome Ms. Gail Shearer, who is currently director of health policy analysis at the Consumers Union. She has a decade of experience analyzing health care finance policy with a consumer perspective, shaping legislative proposals, and representing consumers before Congress.

We are happy to welcome both of you here, and we look forward to your testimony. Please try to keep within the 5-minute rule if you can; but if you do not, do not worry about it.

Ms. Shearer, why don't you proceed?

STATEMENTS OF GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC; AND TERRY HUMO, ROSELAND, NJ, ON BEHALF OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, WASHINGTON, DC

Ms. SHEARER. Thank you very much, Chairman Jeffords, for inviting Consumers Union to testify on the implementation of the Health Insurance Portability and Accountability Act.

Thanks to HIPAA, hundreds of thousands, maybe a few million, consumers will avoid onerous preexisting condition exclusions and will be able to get and keep health insurance that would not have been available without the bill.

I had a call just last week from a small employer who will benefit from these provisions since one of its employees with breast cancer who is now covered by COBRA will be able to remain continuously insured without a new preexisting period. It is very exciting that as time goes on, more and more consumers will begin to see the very real benefits from this bill.

We commend this committee for holding this important hearing to explore the implementation issues. My testimony will address several areas where there are early warning signs of problems that need the attention of Congress.

The best way to minimize these problems is to get all the appropriate Federal agencies and the Congress working to make sure the ambiguities of the law are clarified and to take steps to prevent unscrupulous players in the market from exploiting consumers in order to line their own pockets.

In my statement, I will address the following issues—portability provisions, long-term care insurance, medical savings accounts, niche insurance products that are sold to seniors, and criminalization of asset divestiture.

First, on the issue of portability, perhaps the most important improvement that HCFA makes in the health insurance market is the portability protection it provides consumers who are able to remain continuously insured. There are indications that the intent of HIPAA may be undermined in some States where the powerful insurance industry puts pressure on State legislatures to roll back earlier State reforms that went further than the provisions of HIPAA. If they are successful, the result could be the lack of availability of coverage to individuals and higher premiums for high-risk groups that are now restrained in some States.

I would like to mention that we were very encouraged this morning to hear discussion of the counseling programs for senior citizens that exist now in each of the States. We would recommend that this Congress establish a counseling program to provide insurance counseling for people who are under 65, modelled on the very successful insurance counseling and assistance program for seniors.

I was really heartened by the comments from Senator Collins, Senator Murray, Senator Wellstone and Senator Enzi along these lines.

It is very frustrating for consumers to get balance from agency to agency, and the acronyms that were flying in this room this morning—OBRA, ERISA, this and that; and you go to the State, and they say, oh, no, you go to the Federal Government; the IRS

gets involved—it is very frightening for consumers, and they need to have a place to turn to get the real answers to their questions.

I would like to emphasize how very important these portability provisions are for consumers. The legislation was several years in development, and the final bill makes provisions for good faith compliance on the part of employers to determine creditable coverage. Employers already need to have in place fairly sophisticated systems in order to comply with other State and Federal legislation such as COBRA, and in light of the importance of these new protections for consumers, employers should be held to the requirements of the law.

I was troubled to see in some written testimony the suggestion that if regulations are delayed, then implementation of the Act should be delayed. Consumers simply cannot afford any further delay in the realization of the portability gains.

Turning to long-term care insurance, the private long-term care insurance market has many problems including the absence of built-in inflation protection, confusing and varying benefits, and the potential for premium increases that are not anticipated. HIPAA creates inconsistencies between Federal law and State laws and regulations. The HIPAA provision for tax deductibility for long-term care insurance has made a complicated market even more confusing for consumers. Consumers may have the choice between purchasing a tax-qualified policy that provides little long-term care coverage or a policy that is not tax-qualified but provides comprehensive protection.

The Department of the Treasury should study the inconsistencies between HIPAA and State law and should provide materials that will protect consumers. Without such assistance, many consumers will be pressured into making decisions that could be wrong for them.

Turning to medical savings accounts, perhaps the most controversial issue that surfaced during the enactment of HIPAA was medical savings accounts. Congress should make sure that the study of the impact of MSAs that is to be carried out under the GAO be done as carefully as possible so that it studies the potential selection of healthy risks into medical savings accounts and should require the study to be submitted on time.

In oversight of the Department of Treasury, Congress should monitor how the Department tracks the previously uninsured and assure that it enforces the cap on the size of the demonstration strictly.

Another area that bears careful oversight by Congress is the private health insurance market for seniors. In 1990, Congress successfully overhauled this market. The result was a simplified market with ten standard benefit packages and substantial reduction in the sale of wasteful, duplicative policies to seniors. Unfortunately, HIPAA opened the door to expanded sales of unnecessary limited insurance policies to seniors. It creates the very real possibility that there will be many sales of duplicative health insurance policies such as cancer insurance, hospital indemnity insurance, intensive care insurance and terminal illness insurance to seniors. If seniors have one Medicare supplement policy in addition to Medicare, they simply do not need the additional coverage.

We urge Congress to monitor this market carefully and consider eliminating HIPAA's provisions that change the required disclosure statements and redefine duplication of insurance coverage. We do not want to see a return to the days before enactment of OBRA 1990, of seniors being talked into 15 or more overlapping and wasteful policies.

I have some brief comments on the issue of criminalization of asset divestiture, which of course has come up today. I just want to point out to you that there were some ads running in the State of Arizona that basically scared the dickens out of seniors, saying, "You only have until December 31st, 1996 to avoid making the mistake that could toss you in jail. Congress' sneaky new law is the most vicious attack on retirees yet."

As was mentioned earlier today, we are very concerned about this provision and urge you to keep an eye on it.

Holding this hearing is the first step toward successful implementation of HIPAA. Thank you very much for providing us the opportunity to testify. We look forward to working with you to make sure the health care marketplace truly serves the needs of consumers.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Shearer may be found in the appendix.]

The CHAIRMAN. Terry, please proceed.

Mr. HUMO. Good morning, and thank you very much. My name is Terry Humo. I am an attorney with the Memphis consulting firm of Sedgwick Noble Lowndes. It is a pleasure to be here to discuss implementation issues under HIPAA.

I am testifying on behalf of the Association of Private Pension and Welfare Plans, where I serve on the board of directors and have headed a task force dealing with regulatory issues. APPWP's members represent more than 100 million employees who are covered through the workplace.

I have provided the committee with written testimony and will just summarize a few key points.

First, I want to commend you for holding this hearing. I understand it is very unusual for the committee to have oversight hearings during the regulatory process.

APPWP and a vast majority of members fully support the Portability Act and applaud its intent. The success of the Act is going to depend to a large degree on the implementation of the regulations.

There are two very important questions for employers. One, is Congress going to recommit itself to a voluntary system, or is it going to go down the road of mandates? Second, they are concerned about three ingredients of the regulations—will they provide ample time, will the guidance be clear, and will the guidance be flexible?

Let me return for a moment to each of these points.

On the issue of mandates, let me clear up a misconception. Employers will not stop providing health benefits because of mandates. However, they do have a threshold of how much they can spend on benefits. They will either shift costs or redesign their plans in a way to accommodate mandates but shift the burden to employees. Employees, similarly, have a threshold where they can either spend

so much or psychologically reach a threshold where they do not want to spend any more. Mandates raise the cost, cause shifts to employees and cause them to drop out of the plans.

I would also mention that employers will need clear guidance from the agencies and flexibility to implement HIPAA properly. My statement includes several examples of some of the practical problems, and I just want to mention one of them which relates to the certification.

Employers are not going to have a problem providing information for employees; however, for spouses and dependents, it is a practical impossibility. Spouses and dependents move in and off of a plan during an employee's tenure. There is no way an employer will necessary even know that, and there is even more of a problem for Taft-Hartley plans.

We have several suggestions for dealing with this. First, we propose a transition period. Then we recommend that employers be able to rely on employees' personal attestation of coverage for their spouses and dependents.

Mr. Chairman, we have identified several other issues of concern, including the States' ability to go beyond what HIPAA allows, and how will employees be treated who are employees of State and local governments that opt out of HIPAA; how will their certification be provided?

We surveyed a number of our employers to get a sense in preparation for this testimony, and two of the biggest issues for them are the certification and how do they get the information, and another is they want uniformity in regulations; they do not want a multitude of States increasing their regulatory and compliance burden.

Finally, there is a concern about the fraud and abuse rules. Employers are having a difficult enough time trying to grapple with portability much less the accountability portions. Employers are still grappling with COBRA after years of dealing with it. They still do not know how to comply. The regulatory impact of HIPAA is going to determine its success.

I would be delighted to answer any questions, and I thank you again for this opportunity.

[The prepared statement of Mr. Humo may be found in the appendix.]

The CHAIRMAN. Well, thank you. I appreciate the testimony from both of you, and we are going to look to you to help us as we go forward this year to make sure, especially, that you delineate things that can be done by regulation but do not seem to be happening; and we can address those issues and work in that area. But more importantly, if you know about matters that require legislative attention, we want to know that expeditiously also. And you will know better as we go along and you see what regulators are doing and what regulations appear, as well as what you feel needs to be done.

Mr. Humo, in your testimony, you suggest that "public and private health purchasers be encouraged to work together to develop information needed to make better and more informed health care decisions to achieve the objectives of high quality and appropriate health services." Can you give us some examples of those partnerships and what they would focus on?

Mr. HUMO. There are groups working on quality issues, for example, and how to enhance quality of care. That is an issue more for the bigger employers. We represent all kinds of employers, large to small. The smaller employers are just beginning to grapple with that and are working with groups to develop quality standards.

The CHAIRMAN. You stated that the ultimate test of legislation lies ahead in the ability of employers' health plans and plan participants to understand the provisions of the Act. From what you have heard today, do you feel that this is possible? Are the regulations headed in the right direction?

Mr. HUMO. Yes, and we commend the efforts of the regulators. I would point out that the first person employees go to when they have problems is the employer, not to some agency. And the employers by and large are trying very hard to help the employees, but they are having difficulty.

I think that all the proposals we heard earlier today are really helpful, but we need a lot more of that. We need guidance. For example, with the COBRA change notice, employers essentially had 2 weeks from the time they received notice before they had to provide notice of the COBRA changes in HIPAA—2 weeks is not adequate. Employers had to completely divert their attention from the businesses to complying. That is not the way employers can comply, but rather through advance notice, plenty of time and flexibility.

The CHAIRMAN. You stated that the regulations should make a distinction between certificates of prior coverage which must be provided to employees, and those provided to a spouse or the dependents of an employee. Could you elaborate on that?

Mr. HUMO. Yes. With the certificate of coverage certifying the prior coverage, it is very obvious when an employee goes on or off the plan. But a spouse or dependents may come onto the plan at any time during the tenure, perhaps based on the other spouse's employment, or a dependent may go off coverage to go to college. The employer is required under the Act to give certification as soon as someone loses coverage. How would an employer know necessarily that a dependent has gone off to college and is now off the employer's plan or gone onto another spouse's plan?

So that some flexibility, such as in COBRA, where the employee has the obligation to let the employer know of certain events so the employer can then provide that kind of certification—those are some of the types of issues that we are addressing.

The CHAIRMAN. Gail, both you and Mr. Humo commented on the need for understandable languages or provisions that are user-friendly, shall we say. Could you elaborate on this idea and give us some examples?

Ms. SHEARER. Well, just looking, for example, in the long-term care insurance market, consumers are totally overwhelmed, and they are also subject to pressure from insurance agents to buy policies. So that is one policy area where they need to understand what these policies cover, what the fine print means, and it also happens to be an area where the counseling programs have been extremely helpful in translating fine print from insurance policies into what it means for consumers.

So I guess the big point I would like to make is that consumers need some assistance. I have had calls from people who work for small employers who do not really understand what HIPAA means for them, and we are very early in the process, but it is crucial that not only do the Government agencies involved provide information that employers can understand, but somebody has got to be out there to provide consumer-friendly materials in a digestible form that answer their questions.

The CHAIRMAN. In your testimony, you mentioned that you were concerned that perhaps some of the States that had gone farther to provide protections to employees might roll back their provisions to make them consistent with the Federal ones. Can you give us any examples of that?

Ms. SHEARER. Well, we are at a really early stage right now, but I will tell you that the State of Colorado is one where their regulations and their legislation protect individuals, and there are some rating restrictions which go beyond HIPAA.

Now, as I am sure you are aware, the insurance industry has an awful lot of clout in Washington. Well, if you look at what goes on at the State level, consumer advocates are greatly outnumbered, so our concern is that the insurance industry is going to use the flexibility possibilities to their advantage, and given their clout at the State level, it could mean that instead of becoming a floor, as was intended, HIPAA could in fact becoming a ceiling. So we would urge you to keep an eye on how States respond, and if things move in that direction, we would urge you to take note.

The CHAIRMAN. We would urge you to let us know if you know about it, too.

I want to say that we intend to have other hearings this year on consumer protection and HMOs across the board, so I am sure we will be seeing you again and hearing about those things. Thank you.

Ms. SHEARER. Thank you.

The CHAIRMAN. Thank you both very much.

Senator Enzi?

Senator ENZI. Thank you, Mr. Chairman.

I would request unanimous consent that I be able to put a statement in the record as well on this subject.

The CHAIRMAN. Certainly.

[The prepared statement of Senator Enzi follows:]

PREPARED STATEMENT OF SENATOR ENZI

Thank you, Mr. Chairman. The Health Insurance Portability and Accountability Act (HIPAA) addresses some of the most serious obstacles that restrict access to group and individual health plans. The provisions of this bill—which make health insurance "portable"—guarantee the availability and renewability of coverage. They prohibit discrimination on the basis of "preexisting" medical conditions for people who maintain continuous coverage. And, they make it easier for small businesses to voluntarily form purchasing cooperatives. These are all changes that most people agree are needed.

I hope that the Administration will act cautiously when administering this new law. It was the result of the hard work of a bipar-

tisan coalition. Rather than tossing this measure on the great scrap heap of unfinished business, differences were set aside to produce a respectable law. This is the kind of "action" that the American people ask of us. When I meet with the people in Wyoming, the message I come away with is that they simply want "action." They aren't interested in rhetoric, excuses, political maneuvers or "gridlock." In fact, they have had a bellyful of petty, partisan bickering. The people asked for health insurance reform, and Congress delivered. Now the torch has been passed to the Administration, states, and businesses to do their part of the "people's business."

I had the honor of serving in the Wyoming State Legislature for ten years, a city mayor prior to that for eight years both while simultaneously running a small business. All were eye-opening experiences, I assure you. To see the federal regulations process from the other two sides of the equation is truly enlightening.

I believe the purpose of HIPAA is well-intended and it will help out thousands of employees that are "locked" into their current job due to the lack of health insurance "portability." It is important that the spirit of cooperation between federal and state levels remains strong during this law's administrative process. Let's not "sugar-coat" the truth. HIPAA is a federal mandate that intrudes into the territory that has been the traditional domain of states and issuers. This law contains provisions that establish uniformity among states in regards to health insurance portability, accessibility, and renewability. States have had, and must continue to have, the ability to regulate the health insurance market. This law should not be used as a vehicle to do otherwise.

This important Act places an emphasis on state flexibility—which is essential. I do not now nor have I ever bought into the notion that the federal government is somehow "blessed" with a greater knowledge of how to protect employees than state officials. This law is written to give states the ability to implement their own plans for coverage. The states cried for greater liberty when handling the vexing issue of health insurance. This law contains language that provides states with just that. Even the President in a dramatic departure from his earlier proposal for a government-run health care system has embraced health insurance reforms that are incremental and far more logical. Indeed, the President's government-run health care proposal is a sunken, bureaucratic, luxury liner. Let's not attempt to raise the Titanic. Although each of us can think of various ways in which we would like to expand upon HIPAA, the reality is that the bipartisan appeal of this law would have been utterly lost if Congress had gone too far in amending it.

The purpose of this hearing is to keep this law on track and achieve what it is intended to do. Congress will continue to press forward and enhance the quality, affordability and the availability of health care in this nation. We won't get the job done with smoke and mirrors. We will get the job done with communication, cooperation and a commitment to achieving the goals envisioned by those who drafted and passed this legislation.

Senator ENZI. Thank you.

Ms. Shearer, you made a comment in your testimony hoping that the dates would not get rolled back if the regulations were not in

place in sufficient time. We were assured in an earlier panel that the April 1st date is realistic. In the last panel, Ms. Wilson made a comment that she hoped that they would divulge some of the things that are going to be in these even earlier so that the States can begin work on it, but it is still going to present a problem for some States.

My own State will not be meeting until after those; they will have a budget session, and they will use 18 days to do that, and they will try to pack in some other legislation with it. But I hope there will be some concern and consideration for the fact that they are working on their regulations in a timely manner and as quickly as they feel capable of doing and as quickly as they would on any law that is passed.

Is your group going to be providing additional pressures to have them hold special sessions?

Ms. SHEARER. We do not have efforts in many States. I do not know that we will put that kind of pressure on, but I guess the message today—and I think that this is a sentiment that was expressed in an earlier panel—is that the Federal agencies should meet the schedule that they have set out, and I would hope that you would get the message that these issues are so important to consumers that delay should be avoided if at all possible.

So I think that everybody is approaching this with a sense of understanding, but these are urgent issues to consumers, so we would hope that delay could be avoided.

Senator ENZI. OK. We have placed a lot of emphasis this morning on the Federal agencies and the States and the insurance companies. As the representative of Consumers Union, what is being done to educate the employees and the employers at this point in time? Is anything being done to get the word out on the potential for this?

Ms. SHEARER. I cannot really answer that. I work for the publisher of Consumer Reports magazine, and I am expecting that Consumer Reports will have a role to play in educating consumers, but we do not really talk to the employer or employees directly, so I cannot really answer that.

Senator ENZI. Are you aware of any attempt out there by consumers groups to help educate the employees and the employers?

Ms. SHEARER. I am not. I think that we are probably at a pretty early stage. I think that the Federal agencies have got to start with certain information, but I am not aware of what other consumer groups might be doing in that area.

Senator ENZI. Thank you.

We talked a little bit about litigation, one of my favorite things. Do you anticipate any increase in litigation stemming from the rules that are coming out on this—I think you implied that in your testimony—and if so, what kinds?

Mr. HUMO. I think there is a direct correlation between the amount of litigation and the clarity of the regulations. It is when there is a difference of opinion over what the regulations say that allows room for differences, which leads to litigation.

The clearer the regulations, the happier the employers and the happier the employees, because it resolves the issues there, and that is where they should be resolved.

The most inefficient way to resolve issues is in court; the most efficient way is through clear regulations. The employers want to know what they are supposed to do; give them their marching orders and let them do it, but do not leave them in confusion.

Senator ENZI. And I have to agree with your earlier comments that the employers are still adjusting to COBRA. I belong to the Society of Human Resource Management, which is a group of specialists across the Nation who work with medium to large-size businesses, and I know they have a lot of workshops and questions that deal with the intricacies of that law, and now we are adding another one that interfaces with that law, and I have to agree with the need to eliminate any ambiguous language that is in there.

How would each of you rate the communication that your organizations have been able to have with the agencies in charge of this, and would you have any suggestions for improving that communication?

Mr. HUMO. I think it has been excellent. I think they have shown considerable willingness to listen to us, to meet with us. We commend them whole-heartedly.

Senator ENZI. Good.

Ms. SHEARER. I would agree with that, and they have been very open to receiving comments and to considering them.

Senator ENZI. Thank you. It sounds like everything is on track, Mr. Chairman.

The CHAIRMAN. I want to thank you all, and especially all the witnesses today who provided their testimony in a timely manner so that staff and the members had the chance to review the testimony before coming here today. I think it allowed us to make this hearing much more successful and more expeditious.

Senators Warner and Dodd have requested that their statements be included in the record, and that will be done without objection.

[The prepared statements of Senators Warner and Dodd follow:]

PREPARED STATEMENT OF SENATOR WARNER

Mr. Chairman, I am pleased to participate in this important hearing on the implementation of HIPAA, the Health Insurance Portability and Accountability Act, better known as the Kassebaum-Kennedy bill.

This landmark measure was signed into law during the last session of Congress to help extend health insurance access to more than twenty million Americans. By working to "close the gaps" which have existed in health insurance coverage for portability, renewability, and with pre-existing conditions, we have taken on a series of major reforms in the health care marketplace.

My colleagues will recall that these "market-based" reforms were the starting point for the so-called Kassebaum-Kennedy bill, and before that, they were the very core elements of the Republican health care reform bill of 1994 presented as an alternative to the universal coverage plan developed and proposed by President and Mrs. Clinton.

This morning, I look forward to hearing a progress report on the enormous task of implementation.

We have before us three carefully selected panels representing those with the primary responsibilities for Federal and State regu-

lation, private sector implementation, as well as a consumer advocacy group.

We will learn that far more than 20 million Americans will be affected. In fact, the health insurance plans of more than 145 million working Americans will ultimately be modified in some way.

I understand that that the new public law (P.L. 104-191) has placed regulators at both the federal and state levels, including the Commonwealth of Virginia, on a rather fast track. It is our hope to hear today what further actions may be required of the Congress if implementation is to proceed in a timely fashion.

Although I am a new member of the committee in this 105th Congress, I am certainly aware that the Kassebaum-Kennedy bill was a bipartisan effort, and that the legislation could not have been so successfully achieved without the close cooperation of Members on both sides of the aisle as well as the Clinton administration.

I am certain that the same spirit of cooperation will continue as the process of implementation continues. I look forward to working with both Chairman Jeffords and the ranking minority Member, Senator Kennedy, as we work to make the goals of the health insurance portability and accountability act a reality for the American people.

Prepared Statement of Senator Dodd

Mr. Chairman, thank you for holding this oversight hearing on the Kassebaum-Kennedy Health Insurance Portability and Accountability Act of 1996. We all appreciate your strong support for this legislation in the last Congress, and your commitment to seeing it implemented correctly in the current Congress.

The Kassebaum-Kennedy health insurance law will bring badly needed health security to millions of Americans. As you remember, passing this historic legislation was a long and difficult process. After this committee unanimously approved it, a year went by before it finally became law. Given the importance of this new law and the tremendous amount of effort needed to bring it about, this Congress must vigilantly ensure that Kassebaum-Kennedy is implemented successfully.

While we celebrate the accomplishment of enacting health care portability, it is important to realize this is a first, not the last, step toward meaningful health care reform. For example, at the heart of Kassebaum-Kennedy is the guarantee that if you lose your job, you will not be automatically expelled from your group health plan. Despite this important guarantee, many displaced workers may still lose coverage for the simple reason that they cannot afford the premiums without a paycheck. That is why I support the temporary premium assistance for workers who are between jobs, as proposed in the President's balanced budget plan.

While a majority of the uninsured lost their health insurance to due a job change, other action is needed to help the millions of workers and their families whose lack of health coverage arose without any change in employment status. The many gaps in our current health care system have been especially unfair to our Nation's children.

The need to do better for our Nation's children has become increasingly apparent over my many years of work on children's health issues. Today there are 10 million uninsured children in the United States. This figure represents one out of every seven children and one-fourth of all uninsured persons. The statistics paint a picture of uninsured children that contradict what may be many people's preconceptions.

For example, 88 percent of uninsured children, nearly nine out of every ten, have working parents; 64 percent, nearly two out of three, have parents who wok full-time, year-round. More than three of every five uninsured children live in two-parent families, and two-thirds are in families above the poverty level.

Being uninsured causes many people to go without the health care they need, and this causes the most severe consequences for children. For example, even a simple ear infection, so common among small children, can lead to permanent hearing loss if left untreated. Health coverage for children is a worthwhile investment which essentially pays for itself by preventing costlier health problems in the long term.

So Mr. Chairman, I'm glad we are watching the implementation of one of last year's great successes, the Kassebaum-Kennedy law. But at the same time, we must make it a priority in the 105th Congress to ensure that children and hard-working families have access to affordable health care.

The CHAIRMAN. There are several common themes that have been raised during this oversight hearing, and I just want to go over those briefly.

First, it appears that the issues relating to the certification of coverage need to be addressed with great care. I would encourage the agencies to make the certification process as simple and uniform a process as possible.

Second, in the event that some States allow the Federal Government to enforce the law relating to the individual insurance market provisions, there is a potential for that to be misread as a significant shift in the State's traditional role as insurance regulator under McCarran-Ferguson. I do not feel that is Congress' intent and would encourage the agencies to provide the States with as much flexibility as possible on this issue.

Finally, while I recognize the time lines for completing the regulations are very short, it appears that the three Federal agencies have done an excellent job in involving the States and the private sector in defining the regulations. The testimony from HIAA that: "we have been impressed with the dedication and efforts with which the agencies have approached their responsibilities," and from BlueCross and BlueCross, where they "applaud the Departments of Labor, Treasury, and Health and Human Services for the efforts they have made to elicit comments from affected groups and industries," is very high praise, and I like to see that.

I would especially like to express my appreciation to the key staff at the Department of Labor, HCFA, IRS, and Treasury who are working with us on these regulations and also on the implementation of HIPAA, and I will submit a list of their names for special recognition and commendation to be inserted in the record.

DEPARTMENT OF LABOR

Arzuaga, Pat; Nelson, Holly; Campagna, Lou; Pedulla, Diane; Connor, Mark;Piacentini, Joe; Golding, Debra; Scheingold, Amy; Hunter, Jack; Swiatek, Anne; Maguire, Dan; Traw, Kelly.

DEPARTMENT OF THE TREASURY

Bortz, William; Schwimmer, Mark; Constantine, Eleni; Tawshunsky, Alan; Hamelburg, Mark; Weinheimer, Russ; Knopf, Kevin.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Adolph, Maureen; Kral, Joan; Bishop, Lloyd; Long, Suzanne; Bruggy, Michelle; Olio, Phil; Brummel, Richard; Pierre, Jeffri; Burner, Sally;Saunders, Gertrude; Coons, Thomas; Schulkin, Vicki; Hance, Mary Beth;Slackman, Joel; Holstein, David; Thomas, Marc; Jensen, Tracy; Walton, Julie; Jones, Dale; Zarabozo, Carla.

I would like to thank the witnesses for their testimony today, and I hereby adjourn the oversight hearing on this very important piece of legislation. Thank you all for coming, and I expect we will be back again.

[The appendix follows.]

APPENDIX

Prepared Statement of Bruce C. Vladeck

INTRODUCTION

Cood morning, Mr. Chairman, members of the Committee. Thank you for inviting me to speak with you this morning.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) enhances the "portability" of health insurance, allowing many workers to maintain insurance coverage if they lose or leave their jobs. The Department of Health and Human Services, through the Health Care Financing Administration (HCFA), has a significant role in the implementation of this law, and we applaud this committee and the bipartisan effort in Congress for passing this very important piece of legislation.

The implementation of the insurance reform provisions of BAA will require HCFA to assume new roles in relationship to State regulation of health insurance and health coverage. These new roles are entirely consistent with our commitment to improve access to health insurance for all Americans. We have been engaged in a series of meetings with States insurers, advocacy groups, and the public as we prepare to implement the law. We welcome the challenges this work brings to us, and we look forward to successful and timely implementation.

Today, my testimony will focus on the process of promulgating the insurance reform provisions relating to BAA.

WORKING WITH OTHER DEPARTMENTS

The Departments of Labor, Treasury, and Health and Human Services share the implementation of the law regarding health coverage offered through employment-related group plans. I am pleased to report that we have been working together very effectively.

HIPAA's portability provisions provide for overlapping responsibilities for the three Departments. In other areas, each of the Departments has somewhat different jurisdictions and authorities. For example, the Department of the Treasury is responsible for the provisions relating to tax treatment of group plans, while the Department of Labor is responsible for the regulations governing group health plans under ERISA. The Department of Health and Human Services, through HCFA, has jurisdiction over the portability provisions affecting the States and governmental sponsored group health plans.

HIPAA requires the Secretaries of the three Departments to issue regulations to carry out the portability provisions by April 1, 1997. Congress set this time-trame to ensure that the group-to-group and individual to group portability protections be in place as soon as possible. We are working diligently to meet these goals.

HIPAA also requires the Departments to execute a Memorandum of Understanding (MOU). We have been working towards a formal MOU. We are very aware that the initial regulation is just the beginning of the work, and the hard parts are going to be the interpretation and enforcement that follow. We have found that the regulation process has been very valuable in familiarizing ourselves with the other agencies' practices and protocols. We believe it is important to complete the regulations, and then use the experience gained in that process to develop the MOU.

Public comments will also be received and taken into account as part of the review of the implementation of HIPAA's provisions that will be made by OMB under EO 12866. All three Departments began meeting on a regular basis immediately after the passage of HIPAA. Interagency teams now work with each other several days a week, and we have found that working together and making decisions by consensus is both challenging and educational.

COMMENT SOLICITATION—DECEMBER 30, 1996 NOTICE

We realized very early in the process that it would be important to obtain input from States, insurance regulators, employers, insurers, consumers, and their associations. Our initial meetings with some groups convinced us that an opportunity for comment should be made available to a broader spectrum of interested parties. As a result, the three Departments published a solicitation of comments notice in the Federal Register on December 30, 1996. Comments were due by February 3, 1997, and now we are analyzing these comments. This notice has been very productive in highlighting issues that are of special concern to various sectors of the public.

WORKING WITH THE STATES

As I have stated earlier, HIPAA requires HCFA to assume new roles in relationship to State regulation of health insurance and health coverage. Therefore, we have been working closely with the States and the National Association of Insurance Commissioners (NAIC) in promulgating the regulations. Also, we have met with many state groups, such as the National Governors' Association, and the American Public Welfare Association's National Association of State Medicaid Directors. We are grateful for the time and effort that many State people have spent in educating us.

GROUP INSURANCE MARKET

We recognize that the responsibility for overseeing the actions of the insurers offering coverage in the group market rests with the States, not DHHS. The States have the expertise and depth of experience necessary to successfully fulfill this role.

The NAIC has been working to identity the changes in their model laws and regulations that would be needed to conform to the HIPAA provisions. They have assembled a significant body of advice for States, which they have shared with us. We expect that through this input, as well as through our April 1 regulations, the States and insurance industry will achieve timely and effective implementation of the law.

It is important to note that the States are not required to send us their updated group market laws or regulations, and we have no authority to approve or disapprove them. Although we have the authority to intervene if a State is not substantially enforcing a provision of the law, we intend to work closely with States to minimize the chance of this happening.

Let me now explain HCFA's role in implementing the regulations for the individual market.

INDIVIDUAL INSURANCE MARKET

HIPAA incorporates provisions in the Public Health Service Act that assure access to the individual insurance market, on a guaranteed issue, guaranteed renewal basis, without preexisting condition exclusions, for certain "eligible individuals", as defined in the law. The implementation of these provisions is the sole responsibility of the Department of Health and Human Services, and will be administered by HCFA. However, the implementation of these provisions is closely tied to the certification of creditable coverage as provided for in the shared Department provisions on group-group portability. Thus, HCFA is developing these regulations in close association with the interagency working group.

In drafting the individual market provisions, Congress deferred to the States in the regulation of insurance, and afforded the States great flexibility. We believe this is appropriate since there are great differences among States and their rules for the individual market.

In the individual market regulations, we will emphasize that the states have a choice—to implement an alternative mechanism or to implement the Federal provisions. As in the group market, we will formulate the rules with an open process.

STATE ALTERNATIVES IN THE INDIVIDUAL MARKET

As I mentioned earlier, States have the option to choose to implement an alternative for their individual market. However, due to the effective dates and deadlines in the law, the States cannot wait for our regulations to be issued to develop alternative mechanisms to assure group to individual portability in the individual market. The law is effective on July 1, 1997, and our regulations are due for publication on April 1, 1997. Therefore, a State can submit a notice to us by April 1, 1997 indicating the State's intent to implement an alternative, including detailed description of its proposed mechanism and its implementation plan. States must implement their alternative by January 1, 1998.

Recognizing that the States have many questions about the law and the information needed to review an alternative, we issued a notice on January 13, 1997, offering guidance as to how to proceed in the absence of regulations. This notice clearly expressed substantial flexibility in both documentation and in the range of mechanisms that we would view as acceptable, while at the same time strongly noting our commitment to assuring that eligible individuals have access to coverage within the terms of the law.

CONCLUSION

Again, Mr. Chairman and Members of the Committee, this law helps many workers and families keep health insurance when they change or leave their jobs. HCFA is committed to working with the other Departments to meet the statutory implementation deadlines. You have asked, Mr. Chairman, if there is anything you can do to help. At this point, I am pleased to say that there are no legislative changes needed for initial implementation. We will continue to listen to and work with the States, the public, and other affected parties with respect to the health insurance portability provisions in the group and individual markets.

We congratulate you for passing this bipartisan legislation, and we hope that Congress will continue the effort to improve the availability and affordability of health insurance in the United States.

Again, thank you for this opportunity to appear before you. I would be happy to answer any questions you may have.

Prepared Statement of Olena Berg

INTRODUCTION

Good morning, Mr. Chairman, members of the Committee. Thank you for inviting me to speak with you this morning concerning the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

First, let me applaud this Committee for your efforts that were critical to the passage of this law. HIPAA presents an opportunity to provide America's workers and their families with important protections in their health benefit coverage, and through the hard work of this Committee and many others, millions of Americans will be able to enjoy greater security in their health care coverage. The Administration believes this is a useful model as we address other health care issues in the future.

In enacting HIPAA, Congress wanted these protections in place as soon as possible and, therefore, gave the responsible Departments a short timeframe in which to implement them. We are working very hard to issue regulations necessary to begin implementing the law so that workers and their families can rely on having health care coverage when they change jobs or health plans. At the same time, we are trying to ensure that businesses face as few additional costs and burdens as possible in complying with the law's requirements.

OVERVIEW OF ERISA UNIVERSE

Before I address the Department's role in implementing HIPAA, let me provide a brief overview of our role in regulating health benefits. Through its Pension and Welfare Benefits Administration, the Department enforces and administers the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, the Department has regulatory authority over 2.5 million private sector, employment-based health benefit plans covering 125 million workers and their families. Seventy-two percent of the entire workforce and 64% of the nonelderly population receive health coverage through employment-based plans. Payments by ERISA plans for benefits and other expenses constitute one dollar of every four spent on health care.

ERISA imposes federal standards concerning the disclosure of information to plan participants and beneficiaries, reporting of information to the federal government, and fiduciary responsibilities concerning the management of health benefit plans. HIPAA amended portions of the disclosure provisions, modified the continuation health coverage requirements under COBRA, and added further federal requirements regarding portability, renewability, and nondiscrimination through its amendments to ERISA.

These changes to ERISA make it much easier for workers to change jobs and maintain health care coverage. The General Accounting Office estimated that about 25 million people will befit from these protections. Nearly 21 million people, primarily those who change jobs and their dependents, will benefit from the provisions limiting preexisting condition exclusions. And millions more who have been unwilling to leave their job for a better one out of concern that they would lose their health care coverage would also benefit.

OUTREACH EFFORTS

In addition to these changes to ERISA, HIPAA's portability, access, and renewability provisions also amended the Internal Revenue Code and the Public Health Service Act and provided shared responsibilities for the Departments of Labor, Treasury, and Health and Human Services. Recognizing that BAA is a comprehen-

sive statute and that there was a need for guidance in the short term, the Departments undertook a series of initiatives to give such guidance.

For example, HIPAA made changes to the COBRA rules and employers were required to notify participants of those changes by November 1, 1996. Given the short time period within which employers had to send the notice, we knew that employers would appreciate guidance. Accordingly, we issued a technical bulletin on October 15, 1996, which not only described the changes but also gave a model notice that employers could use to satisfy their responsibilities. We did this quickly because we wanted to be as helpful as possible to employers in getting important information to plan participants. We have received very positive feedback from the employer community on the usefulness of this bulletin and are pleased that it has facilitated compliance with the law by many employers.

In order to get basic information to employers and participants as quickly as possible, we published a booklet, "Questions & Answers: Recent Changes in Health Care Law," on December 18, 1996. Since then, we have distributed over 26,000 booklets and continue to receive requests for copies. It is also available on the Internet through the Labor Department's home page. Judging by the number of requests and "hits" on the Web that we have received, we believe that it has proven to be a useful tool for employers as well as participants.

In addition, we have been giving speeches to employer groups and others to spread awareness of HIPAA's protections and requirements. We have also met with many groups as well as members of your own staffs and other Congressional offices.

I am glad that we have been able to take these steps in facilitating an open process, one in which the public has many opportunities to give us as much feedback as possible. Public comments will also be received and taken into account as part of the review 0f the implementation of HIPAA's provisions that will be made by OMB under Executive Order 12866.

I am proud that we have been able to let so many people know so quickly of the protections they can expect under BAA and so many in the plan sponsor community of the responsibilities they will have under the law. These steps are helping us achieve our goal of working with the private sector as much as possible to ensure individuals get the protections Congress has given them in a manner that is manageable for all involved.

RULEMAKING PROCESS GENERALLY

As I noted above, HIPAA's portability, access, and renewability provisions provided overlapping responsibilities for the Secretaries of Labor, Health and Human Services, and Treasury and are known as the "shared" provisions. Of course, other parts of HIPAA are the primary responsibility of only one Department, such as the individual market portability provisions, which are the responsibility of the Department of Health and Human Services; and certain disclosure provisions, which are the responsibility of the Department of Labor.

HIPAA requires the Secretaries of the three Departments to first issue regulations to carry out the portability provisions by April 1, 1997. In setting this timeframe, Congress wanted to ensure that the group-to-group portability protections be in place as soon as possible, and the three Departments are working diligently to do so. Our overarching goals—which implement Congressional intent—are to ensure that the rules implementing the "shared" provisions are consistent, regardless of the Departmental jurisdictions, and that HIPAA's provisions are implemented in a manner that provides workers and their families with meaningful protections, while remaining sensitive to the burdens imposed on employers and others. As discussed below, the Departments are currently on track to meet these goals.

Coordinated efforts

The Departments met shortly after HIPAA's enactment and quickly developed a working framework in order to proceed with the drafting of the regulations. We also are working toward a more formal memorandum of understanding (MOU). The most critical aspects of the MOU are those that lay down the road map for the future—for how the Departments will interpret and enforce the law. The regulatory process is providing us with insight as to the most appropriate roles for each agency in interpreting and enforcing HIPAA, and this insight will be incorporated by the Departments into the formal MOU.

To best manage the regulation drafting process, staff have been assigned to multiple interagency working groups. A lead agency was designated to develop an initial draft of each relevant provision, and since then the members of the working groups have been working in a collaborative process to work through the issues and come to an agreement. These pups meet on an almost daily basis. Staff will also work together in a larger policy group to finalize regulatory language. As I will discuss

further below, this drafting process will incorporate comments received in response to a request for information which we issued. The regulations drafted by these working groups will be reviewed by each Department and submitted to the Office of Management and Budget for Executive Order 12866 review prior to publication in the Federal Register.

We are making substantial progress in developing regulations on the shared provisions, and we believe that we are on track to meet the April 1 goal.

IMPLEMENTATION OF HIPAA'S PORTABILITY PROVISIONS

In an effort to listen to all interested parties as we develop the regulations, we have made a broad-based request for information. This past December, we published in the Federal Register a request for comments on the portability regulations to ask all members of the public for their input. In addition to inviting comments on any and all issues, we specifically raised whether the regulations should include a model certification that generally could be used to certify an individual's period of creditable coverage. We received a significant number of comments from the public before the comment period closed on February 3, and we are reviewing them in developing regulations.

The regulations will be based on these comments we have received to date and on our conversations with the public. They will be fully effective regulations that employers can rely on. However, because of the short time period Congress provided to develop these regulations, we also intend to ask for public comments after they are issued and will consider the need for any changes based on the comments. This would allow us to further modify the regulations if needed before January 1998, when most plans will become subject to HIPAA's requirements. Approximately 75% of group health plans will not have to conform until the plan years that will begin in 1998.

HIPAA provides sufficient flexibility to allow for the implementation of its protections without unduly disrupting plan administration. It gives plan sponsors and others the protection of a good faith compliance period for their efforts in meeting HIPAA's requirements. They will also allows individuals to show their own records to establish previous coverage.

I would like to briefly highlight the provisions that amend ERISA. The centerpiece of the shared HIPAA provisions for the Department is the portability provisions that allow an individual to get credit for prior health insurance coverage to reduce any preexisting condition exclusion under a new employer's health plan. These portability provisions are set forth under amendments to ERISA.

Our efforts to issue regulations by April 1 target the portability provisions which address preexisting condition limitations and certification of previous health coverage. We anticipate that work will continue on other provisions following the publication of the portability provisions.

Preexisting condition limitations: HIPAA's amendments to ERISA limit the ability of group health plans and health plan issuers to exclude coverage for preexisting conditions. To be a "preexisting medical condition," medical advice or treatment must have been recommended or received for that condition within six months prior to the individual's enrollment in the health plan. Moreover, even if a preexisting condition exclusion may he imposed, it may be no longer than twelve months (or eighteen months for certain individuals who enroll late in the plan). And the twelve month exclusion period must be reduced by the length of any previous health coverage. The only exception is if the previous coverage ended 63 days or more before the individual's enrollment in the new health plan; in such a case, HIPAA's portability provisions do not apply (i.e., the new group health plan or health plan issuer may impose the full waiting period).

Another important protection under this section is the ban on imposing a preexisting condition exclusion for a newborn or an adopted child, or a child placed for adoption, if the child becomes covered within thirty days of birth, adoption, or placement for adoption.

Certification of previous health coverage: To receive credit for the previous coverage, an individual will provide his or her new health plan with a certification from the individual's previous group health plan or health insurance issuer. This process of providing evidence of previous coverage is a major focus of our efforts to issue regulations by April 1, 1997.

Effective dates of the portability provisions: Tracking when these amendments to ERISA become effective can be somewhat confusing. Plans are subject to the portability provisions as soon as a new plan year starts after June 30, 1997. Most plans will not come under the new requirements until January 1, 1998, as I noted above.

However, on the day HIPAA was enacted, all group health plans and health plan issuers became subject to responsibilities related to certifying an individual's previous coverage at least as far back as July 1, 1996. This is because if an individual changes group health plans on July 1, 1997, he will need to show proof of having had up to twelve months of previous coverage in order to reduce any preexisting condition exclusion periods under the new group health plan.

CONCLUSION

With the passage of HIPAA, Congress gave workers and their families important health coverage protections that allow workers to change jobs without fear of losing coverage.

Congress recognized that individuals will want these protections as soon as possible. To meet these expectations, Congress required that we establish a regulatory framework that ensures a rapid implementation of the law. The provisions of the law and the framework we have developed gives us the flexibility to make the law's implementation as efficient and manageable as possible. This framework allows us to get public comments before we issue the regulations in April as well as to get more comments after the regulations are released. It also gives plan sponsors and others the protection of a good faith compliance period for their efforts in meeting HIPAA's requirements. And individuals are given the ability to show their own records to establish previous coverage.

We appreciate having this opportunity to testify about the rulemaking process and assure you that we are working diligently on rapid implementation of HIPAA's protections. You have made a valuable contribution to our efforts by providing a forum in which the views and comments of so many can be shared, and we intend to make the public record of this hearing a part of the record of our rulemaking process.

PREPARED STATEMENT OF J. MARK IWRY

Mr. Chairman and Members of the Committee: I am pleased to present the views of the Department of the Treasury on the implementation of the portability, access and renewability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This legislation, enacted on a bipartisan basis with the strong support of the Administration, provides important insurance reform that enhances health care coverage for American families. We commend this Committee for its critical efforts in achieving passage of this law. We are committed to working to implement the law in ways that protect the ability of workers and their families to maintain their health insurance when they change jobs without imposing undue burdens on employers, plans, insurance carriers, and others providing coverage.

In the spirit of the shared responsibility for the HIPAA group market portability provisions among the Departments of the Treasury. Labor, and Health and Human Services, the three Departments have taken a coordinated approach to implementation. Consistent with this approach, portions of the testimony presented to the Committee today by the three Departments are very similar or identical.

My testimony will focus on the process of promulgating regulations relating to the HIPAA provisions that promote portability of health care coverage. At the outset, however, it is helpful to understand the legislative context and statutory structure within which the regulatory process is proceeding. Accordingly, we will first provide background on the pre-HIPAA laws relating to group health plans, including COBRA, and on the new HIPAA legislation.

BACKGROUND

Laws Relating to Group Health Plans

In General. The States generally have the primary regulatory authority over the sale of insurance. Policies offered in connection with group health plans, as well as policies sold in the individual health insurance market, are generally regulated under State insurance law. In addition, even before enactment of HIPAA, group health bans were subject to certain federal requirements under the Internal Revenue Code of 1986, as amended (the Internal Revenue Code) and the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Internal Revenue Code provides substantial tax benefits with respect to group health plans. For example, the value of employer-provided health insurance coverage and reimbursements under self-insured accident and health plans are generally excluded from income and employment taxes.

ERISA includes requirements concerning the disclosure of information to participants and beneficiaries under group health plans and other employee welfare bene-

fit plans, reporting of information to the Federal government, and fiduciary responsibilities regarding the management of these plans The Department of Labor interprets and enforces these ERISA provisions.

COBRA. The health care continuation coverage rules (commonly known as COBRA) were enacted under the Consolidated Omnibus Budget Reconciliation Act of 1985 and have been subsequently amended (most recently by HIPAA). Under COBRA, a group health plan generally is required to offer employees and their dependents an opportunity to elect to continue coverage under the plan at the time of a qualifying event (such as termination of employment). The plan must permit coverage to continue for a specified period, such as 18 months in the case of termination of employment, and the coverage provided must be the same as coverage provided to similarly situated beneficiaries. A plan is permitted to charge up to 102 percent of the "applicable premium" for COBRA continuation coverage. The continuation coverage can cease upon certain events, such as nonpayment of premiums, termination of all of the group health plans of the employer, or coverage by another group health plan that does not include a preexisting condition exclusion with respect to the qualified beneficiary.

The COBRA continuation coverage provisions are part of the Internal Revenue Code, ERISA, and the Public Health Service Act. Under the Internal Revenue Code provisions, which are administered by the Internal Revenue Service, failure to meet these COBRA requirements can result in imposition of an excise tax on employers. The parallel continuation coverage requirements contained in Title I of ERISA are administered by the Department of Labor. The parallel continuation coverage requirements contained in the Public Health Service Act apply to State and local governmental group health plans and are administered by the Department of Health and Human Services.

COBRA includes overlapping regulatory jurisdictions that may be compared with the HIPAA portability regulatory jurisdictions. However, the legislative history of COBRA allocated certain responsibilities among the Departments. Specifically, under the legislative history, the Department of the Treasury has authority to issue guidance regarding the continuation coverage that is required under COBRA, and the Department of Labor has authority to issue guidance implementing the COBRA disclosure and reporting requirements and the authority to enforce COBRA under ERISA. The Department of Health and Human Services administers the COBRA requirements imposed on governmental plans under rules conforming to those issued by the Treasury and Labor Departments.

HIPAA Portability Provisions

In General. HIPAA sets forth Federal requirements relating to portability, access, and renewability of group health plan and group health insurance coverage. (These HIPAA provisions are referred to below as the "portability" provisions.)

The HIPAA portability provisions relating to group health plans are set forth under a new subtitle K of the Internal Revenue Code (sections 9801-9806), a new part 7 of Subtitle B of Title 1 of ERISA, and a new Title XXVII, Part A of the Public Health Service Act. (These portability provisions are referred to below as the "group market" provisions.) HIPAA also added provisions governing insurance in the individual market[1] which are contained only in the Public Health Service Act, and thus are not within the regulatory jurisdiction of the Department of the Treasury (or the Department of Labor) (These portability provisions are referred to below as the "individual market" provisions.)

In general the group market provisions create concurrent jurisdiction for the Secretaries of the Treasury Labor, and Health and Human Services. The statute provides for the three Departments to share regulatory responsibility for most of the group market provisions, although some of these provisions are within the regulatory jurisdiction of only one Department,[2] and others are within the regulatory jurisdiction of only two of the three Departments.[3] None of the group market port-

[1] These provisions are being addressed in the testimony of Dr. Bruce Vladeck, Administrator of the Health Care Financing Administration, Department of Health and Human Services.

[2] For example, HIPAA includes new provisions requiring that participants and beneficiaries receive a summary description of certain material reductions under a group health plan that are solely within the jurisdiction of the Department of Labor, and certain provisions relating to the availability and renewability of health insurance for employers that are solely within the jurisdiction of the Department of Health and Human Services.

[3] For example, HIPAA includes new preemption provisions within the jurisdiction of the Departments of Labor and Health and Human Services that allow certain more stringent State insurance provisions to apply to insured plans.

ability requirements are solely within the regulatory jurisdiction of the Treasury Department.[4]

Limitations on Preexisting Condition Exclusions. HIPAA's portability provisions limit the ability of group health plans and group health insurance issuers to impose preexisting condition exclusions. The statute defines a preexisting condition exclusion as a limitation or exclusion of benefits relating to a condition that is based on the fact that the condition was present before the date of enrollment. Under HIPAA, a preexisting condition exclusion may be imposed only if it relates to a condition for which medical advice, diagnosis, care, or treatment was received or recommended within six months prior to the individual's "enrollment date." In addition, a preexisting condition exclusion may not be applied for more than 12 months (or 18 months in the case of late enrollment) after the enrollment date.

If the individual has previous "creditable coverage," including coverage under another group health plan, the maximum preexisting condition exclusion period must be reduced by the aggregate of the individual's periods of creditable coverage. Coverage may be disregarded if it precedes a 63-day break in coverage (unless State rules require that there have been a break that is longer than 63 days in order for coverage to be disregarded with respect to insurance issued in the State) or if the coverage consists solely of certain "excepted" benefits. In addition, special protections apply for pregnancy, and for newborn children, adopted children, and children placed for adoption.

Certification of Creditable Coverage. To enable individuals to provide evidence of and thus receive credit for, previous coverage H1PAA generally requires that group health plans and health insurance issuers provide certifications of the period of creditable coverage. Certifications must be provided when an individual ceases plan coverage or otherwise becomes covered under COBRA, when an individual ceases COBRA coverage, and in certain cases where a request is made. Because this certification process applies broadly to nearly all group health plans and health insurance issuers, it has been a major focus of our efforts to develop regulations, described in greater detail below.

Special Enrollment Rights. We believe that a fundamental underpinning of the portability provisions is that employees and dependents should have the ability to maintain health coverage even when they change jobs or leave the group market. To that end, HIPAA allows an employee or dependent to elect to enroll in a group health plan under certain conditions involving either the loss of coverage from another group health plan or the addition of a new family dependent by marriage, birth, adoption, or placement for adoption. One of the practical implementation issues that will arise under the new law is the coordination of an individual's existing health insurance continuation and conversion rights with the new special enrollment rules. In certain cases, an individual must exhaust his or her continuation rights (which may involve the payment of premiums for extended periods of time, e.g., 18 months) in order to be eligible for special enrollment. This will present new options that can complicate the health care continuation decisions of a family with an ill member. These new enrollment rights, especially in conjunction with the new limits on preexisting condition exclusions and existing COBRA rules, will enable employees and dependents to enroll when they need coverage, provided they can afford the coverage and understand their rights.

Prohibiting Discrimination Based on Health Status. The HIPAA group market rules prohibit a group health plan or health insurance issuer in the group market from establishing rules for an individual's eligibility to enroll in a plan based on an individual's medical history, evidence of insurability, or other health status-related factors. The legislative history indicates that these include factors relating to personal activities, such as skiing or riding horses. Similarly, a group health plan or health insurance issuer in the group market cannot require an individual to pay greater premiums or contributions based on any health status-related factor. An exception is provided for discounts, rebates, or modifications to copayments or deductibles in return for adherence to "programs of health promotion and disease prevention" (sometimes referred to as "wellness" programs) The need to interpret and apply these new legal concepts (health status-related factors and wellness programs) will be among the issues making implementation of HIPAA more challenging.

Effective Dates. HIPAA includes a number of effective date provisions.

The substantive requirements of the HIPAA group market rules, such as the limitations on preexisting condition exclusions and the prohibitions on discrimination based on health status-related factors, are generally effective for plan years begin-

[4] There are other provisions of HIPAA, outside of the portability provisions, that are within the principal jurisdiction of the Department of the Treasury.

ning after June 30, 1997. For example, in the case of any plan that is maintained on the basis of a calendar plan year, these provisions generally will be effective on January 1, 1998.

Special effective date rules require individuals to receive a certification of their coverage in certain cases before the general effective date of the substantive HIPAA group market rules Specifically, the requirement that a group health plan and a health insurance issuer in the group market deliver to individuals certifications of their creditable coverage upon certain events (e.g., loss of coverage) applies to events occurring after June 30, 1996. However, no certification is required to be provided before June 1, 1997. Certifications are not required to reflect coverage before July 1, 1996, and certifications for events before October 1, 1996 need be provided only upon written request.

Under HIPAA, the Departments are instructed to "first issue by not later than April 1, 1997, such regulations as may be necessary to carry out" the group market portability provisions. At the same time, HIPAA provides that no enforcement action may be taken, pursuant to the group market portability provisions, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by those provisions before January 1, 1998 (or in the unexpected event that regulations are delayed, the date of issuance of the regulations), if the plan or issuer has sought to comply in good faith with those requirements.

These effective date provisions delineate a coordinated implementation time line: April 1, 1997 (for issuance of the regulations); June 1, 1997 (for issuance of certain certifications); July 1, 1997 (earliest effective date for non-calendar year plans); and January 1, 1998 (general effective date for calendar year plans and expected end of the good faith period).

IMPLEMENTATION OF HIPAA PORTABILITY PROVISIONS

The three Departments have been working in concert, as described below, to implement the HIPAA portability rules, including our continuing efforts to take into account comments from the public.

Regulation process

A guiding principle in the process of developing regulations has been to implement HIPAA's provisions in a manner that is faithful to the protections provided for workers and their families, while remaining sensitive to the burdens imposed on employers, plans, insurance carriers, and others. During this process we have taken into account, and will continue to take into account, the comments we receive concerning the portability guidance.

Interagency Meetings and Drafting of Regulations. In enacting HIPAA, Congress established a compressed timetable to govern implementation of the portability provisions. As indicated above, the portability rules generally apply with respect to plan years beginning after June 30, 1997, and HIPAA directs the three Departments to first issue, by April 1, 1997, such regulations as may be necessary to carry out these rules. Further, in adding very similar group market provisions in three separate statutes, Congress created a structure under which the Departments must coordinate their efforts Accordingly, HIPAA provides that the Departments are to execute an interagency memorandum of understanding (MOU) under which departmental regulations, rulings, and interpretations relating to the shared provisions are to be administered so as to have the same effect at all times and enforcement policies are to be coordinated in a manner that avoids duplication of efforts and assigns enforcement priorities.

Personnel from the three Departments met directly after HIPAA's enactment and quickly developed a working arrangement for the development of regulations to be issued by the statutory goal of April 1, 1997. Under this working arrangement, staff from each Department have been assigned to a number of interagency working groups that take responsibility for relevant portions of the regulations. After collective analysis of the issues, personnel were designated to develop an initial draft for each relevant provision. Following circulation of the initial drafts, members of the working groups have been working collaboratively to resolve outstanding issues. The working groups meet on an almost daily basis. In addition, a larger interagency group will be involved in reviewing the drafts produced by the working groups and is coordinating the overall regulatory project. The draft regulations will be reviewed by each Department and submitted to the Office of Management and Budget (OMB) for Exec. Order (EO) No. 12866 review before publication.

The development of HIPAA regulations by three Departments on a collaborative basis is neither an easy nor a simple task. The process has led us to appreciate better the difficult challenge that your Committee, and the other Congressional committees of jurisdiction, corfronted in crafting the legislation. However, we believe

that this process of developing the regulations is proceeding well. The interagency teams are working in a spirit of cooperation and open mindedness, and are actively taking into account the information and views received from the public. We have made substantial progress in developing regulations on the shared provisions, and believe that we are on track to meet the April 1 goal.

At the same time, we have initiated a process for development of an MOU. As the first component, the operational understanding among the Departments is to have personnel from all three Departments work together to draft group market regulations dealing with the shared provisions However, we believe that the most critical aspects of any MOU will be those that create a framework for the future administration of the HIPAA rules after the regulations are issued. i.e., for how the Departments will interpret and enforce the law after it goes into effect. The regulatory process is providing us with insights as to the most appropriate roles for each agency and potential methods for allocation of interpretative authority and enforcement priority. Consequently, after the process of drafting the regulations has been completed, the Departments All be in a better position to develop a formal MOU specifying the allocation of future administrative guidance and enforcement responsibilities. Accordingly, the Departments intend to complete and execute the MOU after promulgation of the initial regulations.

Comments From Interested Parties. Personnel from the Treasury Department have held meetings regarding the portability provisions with representatives of the National Association of Insurance Commissioners (NAIC) and with plan administrators. The Departments of Labor and Health and Human Services have also been meeting with outside groups and, as indicated in Dr. Vladeck's testimony, the Health Care Financing Administration has been working closely with the States as part of its unique role in the process. Personnel from all three Departments, including the Internal Revenue Service, have attended and spoken at conferences, both to educate others about HIPAA and to be educated about concerns and issues raised by those affected by the new requirements. We, of course, also have received and responded to correspondence and telephone inquiries from the public regarding HIPAA.

In addition, last December, the Departments published in the Federal Register a public solicitation of comments on the HIPAA portability provisions. The Departments indicated that they had received comments from the public on a number of issues arising under these provisions. They announced that further comments from the public on all issues under the portability provisions were welcome in order that comments could be taken into account, to the extent practicable, for purposes of developing the regulations before April 1, 1997. We believe that consideration of public comments, both on behalf of employees, dependents, and others seeking health care coverage, and on behalf of employers, plan administrators, and insurance issuers, is, and will continue to be, an essential component of our implementation efforts.

The solicitation of comments also noted that, in response to questions already received, the Departments were considering whether to include in the regulations a model certification that could be used to certify an individual's period of creditable coverage. The Departments indicated that such a model certification might include information identifying the parties involved, whether the individual had at least 18 months of coverage under the plan without a 63-day break, and, if not, the start and end dates of coverage periods (and any related waiting period), but not information concerning the particular benefits provided under the plan. Under this possible approach, information concerning the particular benefits provided under a plan would be required to be furnished only if another plan or issuer, after receiving the model certification, requested additional information in accordance with the statute.

The solicitation of comments specifically requested input on whether a model certification would be useful. The Departments are considering whether a model certification could significantly reduce the potential burdens on employers and insurance carriers, while also making the certification process more effective for employees and dependents. The Departments are considering whether and how a model could facilitate the transmission of coverage information by standardizing the information that employees and dependents receive and deliver to their next group health plan or use to evidence their eligibility for coverage in the individual market Such a model certification approach could minimize the information collection burden and could become the commonly-used standard. Thus far, the idea of a model certification has been well received, and some suggestions have been submitted regarding appropriate formats for a model.

This open comment process has provided the Departments with valuable information to consider during our work implementing the HIPAA provisions. Public comments will also be received and taken into account as part of the review of the implementation of HIPAA's provisions that will be made by OMB under EO 12866. We

also intend, of course, to make the public record of this hearing a part of the record of our rulemaking process.

Other Interim Guidance with Respect to Group Market Provisions

As noted, the Treasury Department has been collaborating with the Departments of Labor and Health and Human Services to implement the statutory provisions. For example, HIPAA required that each group health plan notify, by November 1, 1996, every one of its qualified beneficiaries in the United States who was on COBRA continuation coverage about certain changes to COBRA that were enacted under HIPAA. To that end, all three Departments were actively involved in developing a technical bulletin, issued by the Department of Labor in October of 1996, that not only described the new COBRA provisions, but also functioned as a model notice that could be used to satisfy the notification requirement. We have received favorable comments on the usefulness of this bulletin, and are pleased that it has facilitated the implementation of HIPAA.

CONCLUSION

The HIPAA portability reforms will help employees move more freely from job to job, which should benefit the economy. People will have new health insurance rights that will enable them to obtain coverage even if they have preexisting conditions, to enroll promptly when they lose other coverage or have new dependents, and to participate in group health plans without discrimination based on factors relating to their individual health status.

These are important reforms that we are working hard to implement in a way that will balance the protections they provide to individuals with the burdens on entities that offer health care coverage. Our goal is to issue the necessary regulations by the April 1, 1997 statutory date. After the regulations have been issued, we will continue to take into account public comments as we consider whether changes should be made to the regulations or whether additional guidance should be issued.

Until the regulations are issued, and thereafter, we will continue our efforts to listen to what the public and other affected parties are telling us, both with respect to the need for health insurance portability and with respect to the administrative burdens and requirements imposed on employers insurance carriers, and plans. Moreover, we hope that Congress will continue the bipartisan effort to improve the availability of health care in the United States, including further steps toward the goal of health insurance coverage for all Americans.

The Treasury Department appreciates the opportunity to testify before this Committee concerning the implementation of HIPAA's portability provisions.

Mr Chairman, this concludes my formal statement. I will be pleased to answer any questions you or other Members may wish to ask.

PREPARED STATEMENT OF DAVID H. ENNIS

Mr. Chairman and Distinguished Members of the Committee: My name is David Ennis. I am beginning my ninth term in the Delaware House of Representatives, where I chair the Committee on Economic Development, Banking and Insurance. Today I am speaking on behalf of the National Conference of State Legislatures (NCSL).[1] It is a pleasure for me to be here to discuss the implementation of the small group and individual market reforms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I want to thank those of you on this panel who supported a strong and continued State role in the regulation of health insurance during the long debate last year. The invitation to NCSL to participate in this hearing reflects a continued interest by this committee to address the interests and concerns of the States. NCSL appreciates your interest and support and looks forward to working with this panel to cast aside proposals that would weaken or eliminate the role of States in the regulation of health insurance.

It is fair to say that for me and many of my colleagues across the country, the implementation of the provisions of HIPAA is proving to be more complicated and more challenging than we imagined last fall. It appears that the legislation is proving just as challenging for the Federal agencies charged with the responsibility of promulgating regulations.

[1]The National Conference of State Legislatures is a bipartisan organization created to serve the legislators and legislative staff of the nation's 50 States, its commonwealths and territories and the District of Columbia.

As you know, most States had enacted some small group reforms and a few States had enacted individual market reforms before the enactment of HIPAA. While these State statutes provided the genesis of the Federal legislation and may serve as a base for State programs in the future, every State must review the relevant sections of its insurance code to ensure that no provision directly conflicts with HIPAA, as that would trigger Federal regulation. While in some cases this is largely a technical drafting exercise, it is a time consuming one that will have serious consequences if mistakes are made. In this regard, time is our greatest enemy.

STATE LEGISLATIVE SESSIONS

Short session States, several represented by members of this Committee (AR, IN, IA, MD, NM, VA and WA) are particularly challenged. Some of these States (AR, NM and VA) will be out of session by April 1, 1997. In addition to enacting the necessary changes to their insurance codes to comport with HIPAA, these States must address changes required under welfare reform and other Federal legislation enacted last year as well. They will probably have to do so without regulatory guidance from Washington, D.C.

In hindsight, I can tell you that the effective dates for many of the provisions in HIPAA are unrealistic in light of the work that must be done both in the States and in the Federal agencies to implement the provisions of the Act. Attached for your information is a 1997 Legislative Session Calendar.

STATUTORY CONCERN

I know the focus of this hearing is the regulatory process, but I would be remiss if I failed to mention a statutory provision that may affect my colleagues in the State of Kentucky, the home State of a distinguished member of this committee. The Act was designed to provide additional time for States that do not have session during the one-year period following the enactment of HIPAA. The legislative language describes such a State as a State that has a legislature that does not meet within the 12-month period following enactment.

Kentucky is the only State that has no regularly scheduled session this year, but the legislature met in special session this past December to address workers compensation. It would appear that under the Act, the one State that might have qualified for an extension of time, may not in fact qualify for the extra time after all. NCSL urges you to support an interpretation of the provision that would clarify that the provision pertains to regular sessions of the legislature.

REGULATORY ISSUES

[Notification Procedures for States Implementing "Alternative Mechanisms" in the Individual Health Insurance Market (January 13, 1997 Federal Register)]

The first major statutory deadline for States is the April 1, 1997 date for notifying the U.S. Department of Health and Human Services (DHHS) regarding the States' intent with respect to alternative mechanisms in the individual market. As you know, DHHS published a notice last month providing States with "guidance" on how and what to submit. Noticeably absent was any attempt to "interpret" the provisions of the law. This notice gave us both comfort and pause.

We were pleased that the Department has set out and described a notification procedure, as this answered many process questions. Below are some observations regarding the notice.

(1) The request for submissions within 30 days of the notice is probably unrealistic.

I might also suggest that contacting States that have failed to submit a notification package by February 14, 1997, may not be the most efficient use of DHHS staff time. States that haven't responded by that date most likely have nothing to report.

(2) Failure to provide an interim response to "frequently asked questions" and questions key to the development of acceptable alternative mechanisms within the timeframe that States must submit notification creates a hardship for States.

The notice recognizes that States would like to receive interpretation of key provisions of the Act directly related to defining and developing acceptable alternative mechanisms, then informs us that this information will not be available until DHHS publishes interim final regulations that they expect to publish, "by April 1, 1997."

The delay in publishing this important information necessitates the establishment of a "transition period" to permit States, that have made a "good faith effort" to interpret the law, to bring their program into compliance should their interpretation fail to match that found in the interim final rule. This transition period would be defined, established and described in the rule.

By the time the rules are promulgated and the transition period is established, many State legislatures will be out of session. If despite our "good faith efforts," legislative changes are required, it will be difficult for those States to meet the January 1, 1998 deadline for enacting legislation without incurring the considerable cost of holding a special legislative session. NCSL hopes that if this situation arises that we can come to you for legislative relief and work with you to establish a reasonable transition period that would not require States to hold special legislative sessions solely for this purpose.

Without such relief, or the hope of such relief, there is a strong incentive for States to simply adopt the federal fallback program. We hope that you will continue to support and encourage State innovation and creativity and work with the States on this issue.

(3) Documentation requirements may be more extensive than necessary to determine whether a submission meets the minimum requirements established in the Act.

The documentation section of the notice gives us some pause. If in fact, there is to be a presumption of acceptability when a State notifies the Secretary of its intent to implement an alternative mechanism, the information required by the Secretary to review the mechanism and its implementation should reflect that presumption. It is our view that once a State notifies the Secretary of its intention, and provides information on how the mechanism is "reasonably designed to be an acceptable mechanism as of January 1, 1998," that the plan should be deemed acceptable.

The notice describes the Department's "Standard of Review," as based on "certain principles set forth in the statute and legislative history." The notice further States that the HIPAA conferees intended the "narrowest of preemption." The documentation guidance in the notice suggests that the Department is looking for extremely detailed, and perhaps largely unavailable data (certainly in the short term) from the States. Given the "presumption" language in the Act and the very short timetable for implementation, I hope you agree that the Secretary should focus on the minimum requirements established in the Act and whether the State provides assurances that its plan meets the requirements.

COORDINATION AND CONSULTATION WITH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

In closing I would like to emphasize that while we have some concerns regarding the notice, we are pleased that the Department is making an effort to keep NCSL informed of its progress and that we have been fully informed of the notification process. In addition, the Department has committed to meeting with us regarding the progress of its overall regulatory effort on HIPAA. NCSL, in turn, is committed to keeping our membership informed.

NCSL will continue to work closely with all the Federal agencies involved in implementing HIPAA and looks forward to your continued oversight of the regulatory process.

I would be happy to answer any questions.

[Additional material may be found in committee files.]

Prepared Statement of Josephine Musser

I. INTRODUCTION

Good morning Mr. Chairman and members of the Committee, my name is Josephine Musser. I am the President of the National Association of Insurance Commissioners (NAIC) and the Chair of the NAIC's Special Committee on Health Insurance ("NAIC Committee").[1] I am also the Commissioner of Insurance for the State of Wisconsin. Over the past several years, other members of the NAIC and I testified several times before this Committee regarding issues and legislative proposals surrounding the development of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")(P.L. 104-191).[2]

[1] The NAIC is the nation's oldest association of state public officials, composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. The NAIC Committee is a committee composed of 42 of our members, and was established as a forum to discuss federal health insurance-related proposals and to provide technical advice on a nonpartisan basis.

[2] See Testimony before the Labor and Human Resources Committee of the U.S. Senate of Josephine Musser, Recording Secretary, NAIC, Commissioner of Insurance, State of Wisconsin, March 15 and July 18, 1995; Testimony of David J. Randall, Deputy Director, Ohio Department

Continued

The members of the NAIC Committee thank you for this opportunity to address you this morning. As a consequence of HIPAA, beneficiaries of self-funded plans governed by the Employee Retirement Income Security Act ("ERISA") will soon be afforded several of the same protections already available to beneficiaries of insured plans, particularly in the area of portability. In addition, the legislation retained significant flexibility for the states. HIPAA recognized that the states have paved the way in the area of insurance reform and provided them with flexibility to continue to go beyond the federal law in many areas.

In your invitation to testify, Mr. Chairman, you asked us to focus on the "actual process of promulgating regulations; the extent to which members of [the NAIC] have been able to work with the various [federal] Departments in developing regulations; serious problems [we] may see the States having in implementing the law; and what [you] in Congress can do to assist in resolving any problem areas." In responding to these questions, we have divided our testimony into the following areas: (1) the NAIC's activities to assist the states in implementation; (2) the continuing responses of the states to the implementation of the law, from the perspective of the state insurance regulators who are attempting to assist their legislators and governors through the provision of technical assistance to these policymakers; (3) implementation and interpretive issues raised by NAIC members as they move forward with implementation; and (4) the process of working with the relevant federal agencies as they develop regulations.

Before I begin, I would like to emphasize that my testimony reflects the perspectives of the state insurance departments in their role as regulators and implementors of much of HIPAA with respect to insured health plans. However, as you know, the state flexibility afforded by HIPAA presents the states with many important policy questions, and these decisions are the purview of the state legislatures and governors. To the extent to which the NAIC Committee's testimony discusses the state insurance departments' understanding of the possible direction some states may take regarding these policy decisions, I would like to emphasize, of course, that these responses are preliminary and subject to change based upon gubernatorial and legislative decisions.

II. NAIC ACTIVITIES FOR ASSISTING STATE IMPLEMENTATION OF P.L. 104-191

The NAIC has undertaken a number of activities since the passage of HIPAA in August 1996 to assist its members in implementing the requirements on insurers under P.L. 104-191. These activities have been conducted under the direction of the NAIC Committee. This committee formed a working group, the P.L. 104-191 States Implementation Working Group, to assist state insurance departments in understanding the federal statute and to help comply with the deadlines established by the law. The working group is chaired by Commissioner Glenn Pomeroy of North Dakota, and vice-chaired by Commissioner Kathleen Sebelius of Kansas. The seven other NAIC members on the working group represent states from each of our organization's four regional zones: Vermont and New Jersey (Northeast Zone); Iowa (Midwest Zone); West Virginia and Arkansas (Southeast Zone); and Colorado and Washington (Western Zone).

The working group's assignment was to develop an implementation manual to guide NAIC members and to suggest revisions to the existing NAIC model acts affected by P.L. 104-191. These suggested revisions reflect only those minimal changes which the working group understood to be required by HIPAA. There are seven NAIC model acts that are significantly affected by the law, and several others that will require a few conforming changes. The seven models primarily affected are: the 1992 Small Employer Health Insurance Availability Model Act, the 1995 Small Employer Health Insurance Availability Model Act, the Small Employer and Individual Health Insurance Availability Model Act, the Individual Health Insurance Portability Model Act, the Model Health Plan for Uninsurable Individuals Act, the Model Long-Term Care Insurance Act and the Model Long-Term Care Insurance Regulation. The two models addressing individual market reform and the model for uninsurable individuals are specifically referred to in P.L. 104-191, but need slight modifications to meet the law's requirements.

The working group held a meeting on November 21, 1996, here in Washington, D.C., and two subsequent meetings at the NAIC's 1996 Winter National Meeting in Atlanta. At these meetings, members of the working group discussed proposed revisions to the seven models. All these meetings were public, and the NAIC received extensive comment from representatives of the insurance industry, consumer

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of Insurance, July 25, 1995; Testimony of the Honorable Deborah Senn, Insurance Commissioner, Office of the Insurance Commissioner, State of Washington, July 28, 1995.

groups, and other interested parties on the proposed modifications to the NAIC models.

The working group distributed draft components of the implementation manual to NAIC members and interested parties in November. The working group should have a completed implementation manual ready for distribution by the end of February. The implementation manual will include a detailed analysis of the effect of P.L. 104-191 on the seven NAIC models that are primarily affected. The document containing this analysis is currently entitled "Draft Template for State Implementation of the Health Insurance Portability and Accountability Act of 1996." The manual will also include drafts of the seven models containing the suggested revisions, and a list of many of the questions raised by member departments, with responses which reflect the best understanding of the NAIC Committee at this point. The final implementation manual also will include various charts and summaries to assist states in their implementation of P.L. 104-191. Most of these documents also have been publicly distributed and commented upon in advance.

Another major task of the working group has been to attempt to answer the many questions about P.L. 104-191 posed by member state insurance departments. The working group members have acted as lead regulators within their respective geographic zones to answer these questions from other states within their zones and to communicate with NAIC staff. In addition, the working group is developing a list of interpretive issues raised by HIPAA, with recommendations for clarifying regulations that the NAIC, in the next two weeks, will formally submit to the three federal departments charged with promulgating regulations under P.L. 104-191.

The working group also has directed the activities of the NAIC staff in gathering information from NAIC members about their plans for implementing P.L. 104-191. The working group developed a preliminary survey, which it distributed to all the states in late November. NAIC staff have contacted every state insurance department during the last of week of January to confirm the survey results and obtain more detailed information about each state's implementation plans, as set forth below.

III. STATE IMPLEMENTATION ACTIVITIES

As noted above, I must preface my remarks by emphasizing that the information I will give is preliminary only and subject to change for a variety of reasons. Each state's approach for complying with P.L. 104-191 will ultimately be determined by its legislature, in conjunction with its governor, and those decisions are in the process of being made. Many of the answers reported below therefore are tentative and reflect the understanding of the state insurance departments regarding this process. In deference to those continuing deliberations, the survey results will be provided in aggregate. However, the aggregate information gives some indication of the various approaches under consideration by the states to implement the requirements of P.L. 104-191.

With respect to my state of Wisconsin, Wisconsin Governor Tommy Thompson understands the importance of HIPAA's requirements for the citizens of Wisconsin and other states. While I cannot provide details on Wisconsin's plans for HIPAA compliance at this hearing, Governor Thompson will be providing details regarding his proposals relating to HIPAA and insurance regulation in Wisconsin in his budget message to the state legislature tomorrow, February 12. At that point, I would be happy to provide the Committee with more details regarding Governor Thompson's proposals relating to HIPAA.

The NAIC staff posed questions to NAIC members relating to four categories of insurance regulation affected by HIPAA: the individual insurance market, the group market, the market for long-term care policies, and medical savings accounts.

Individual Insurance Market (See Attachment A)

P.L. 104-191 establishes federal standards for the individual health insurance market, but allows states the flexibility to implement an alternative mechanism that meets certain requirements instead of either the states enforcing the federal standards or the states deferring to federal enforcement. We asked the state insurance departments whether their states intended to adopt an alternative mechanism, to enforce the federal standards, or to take no action and allow the federal government to enforce the law.

Thirty-five insurance departments indicated that their states will probably adopt an alternative mechanism. The most common type of alternative mechanism named by our members is a qualified high-risk pool. Nineteen of those insurance departments indicated that their states plan to establish high-risk pools or conform an existing state high-risk pool to meet the requirements of P.L. 104-191 for risk pools that qualify as an acceptable alternative mechanism. The other sixteen insurance

departments whose states plan to implement an alternative mechanism indicated that their state would probably adopt an alternative mechanism that is not a high-risk pool. Ten of these sixteen states will probably use some type of guaranteed issue requirement to comply with HIPAA. Nine of these ten already require some type of guaranteed issue of policies in the individual market and are conforming their laws to ensure complete compliance with P.L. 104-191's portability and other requirements. In some cases the guaranteed issue requirement already extends to individuals who would otherwise not meet the federal law's requirements. In at least one of these sixteen states, the insurance department may recommend the adoption of the NAIC's Small Employer and Individual Health Insurance Availability Model Act. The other five of these sixteen states may take a various other approaches, some of which incorporate a combination of mechanisms. For example, one state contemplates providing a risk pool for the sickest individuals and requiring guaranteed issue for other individuals.

Nine state insurance departments responded that their states would probably adopt legislation enabling the state to enforce the federal standards.

Six states have not yet made a decision about their approach for complying with P.L. 104-191's requirements for the individual insurance market.

No state insurance department reported that it would recommend that the state take no action as a consequence of HIPAA. In states that fail to take any action to comply with HIPAA, and the state standards do not comport with HIPAA, the federal government rather than the state will have the authority to enforce the standards set by HIPAA for both the individual and group insurance markets whenever there is a determination that the state has failed to "substantially enforce" a provision or provisions of HIPAA.

Group Insurance Market

Large group market: We asked the NAIC members about their state policymakers' plans for amending the laws governing their large group insurance markets to comply with P.L. 104-191. Most state insurance departments indicated that they were recommending that their states make only the changes in the laws governing large group markets that are required by P.L. 104-191. In general, these departments are not advising their states to extend to the large group market any small group market requirements already contained in their laws that exceed the standards mandated by P.L. 104-191. For example, we identified no state insurance department that anticipated recommending legislation requiring guaranteed issue in its large group market unless this is already required. However, three or four states already have rules governing preexisting condition exclusions that are more generous than those of P.L. 104-191 and that extend across all insurance markets. In these states, the insurance departments generally thought that these requirements for the large group market will be retained.

Small group market: We asked the state insurance departments whether their state policymakers would need to amend the definition of "small group" contained in their small group insurance laws to meet the guaranteed issue requirement of P.L. 104-191. There are two dimensions to this question. The first is whether the state, under current law, defines "small group" using different numbers of employees, such as 1 to 25, rather than 2 to 50, the minimum required by P.L. 104-191. The second dimension relates to the federal law's specific provisions for calculating the group size of an employer for any given year; this methodology differs somewhat from that in place in several states.

The state insurance departments indicated that they believe many state legislatures will have to make some conforming changes to ensure that their laws use the same methodology for defining a small group as the federal law with respect to the federal guaranteed issue requirements. With respect to the question of minimum and maximum numbers specified in the state law defining small group, the insurance departments' responses were more varied. Nineteen insurance departments indicated that their laws already defined small group as a group of either 2 to 50 or 1 to 50 and that the numbers in their laws do not, therefore, have to be changed. However, in some of these states the insurance department will recommend other changes to conform to the federal law, but not because the size of the group specified in the state's law is inconsistent with the federal law. The responses of the insurance departments indicate that approximately ten states will have to expand significantly the size of the group that they had defined as "small group." Typically these states defined small group in the range of 2 to 25, but some defined it as 2 to 35 or 2 to 40. At least one state insurance department may recommend that the state change its definition to reduce the size of a small group. In at least twelve states, the numbers used to define small group are close to 2 to 50, but the insurance departments will recommend making the small change in the numbers nec-

essary to comply with the federal law. Finally, in some states, the insurance departments indicated that they did not think the states would have to change their definitions at all.

We also asked the state insurance departments whether their state policymakers might need to amend their states' definition of "small group" for purposes other than the guaranteed issue requirements. Specifically, we wanted to know whether an amendment was contemplated for a state's rating provisions, or for any other purposes besides the guaranteed issue requirements. With respect to rating, twenty-two insurance departments indicated that they did not intend to recommend that state policymakers modify their rating provisions, while twenty departments indicated that they would or might make such a recommendation. In a few instances, the state insurance department indicated that it had not decided on a recommendation. Approximately four states do not currently define small group in their insurance laws.

Long-term care policies

We asked state insurance departments whether their state policymakers planned any changes this year to state laws or regulations affecting long-term care insurance policies. The responses of the state insurance departments divided approximately evenly between those that probably will recommend changes to their relevant statutes and regulations and those that plan to recommend no changes at this time. Approximately twenty-seven state insurance departments indicated that they will recommend amending their laws or their regulations. In some cases the state insurance department already has begun or completed the process for amending the relevant regulation. Twenty-one state departments indicated that they would probably not recommend legislation or attempt to change their regulations this year. At least two departments indicated' that they have not decided on their recommendation.

We also asked each department about the intention of its state policymakers with respect to allowing the sale of qualified and non-qualified policies. Thirty-two departments indicated that their states would probably allow for the sale of both types of policies. Four indicated that their states were considering allowing only the sale of qualified policies. At least six departments had made no final decisions about their position on this question. Many insurance departments indicated that their decisions about how best to regulate long-term care policies were evolving and that they were waiting for the federal government to promulgate regulations pursuant to P.L. 104-191.

Medical Savings Accounts

We asked each state insurance department whether there was any provision of its state's statutes or regulations that would prevent the sale of the high deductible policies used in conjunction with a medical savings account (MSA) qualifying for favorable federal tax treatment. Most insurance departments indicated that they knew of nothing in their states' existing laws or regulations that would prevent the sale of a high deductible plan that meets the federal law's specifications. Forty departments indicated that, in their opinion, no changes were necessary to existing state statutes or regulations to permit the sale of these high deductible policies. Eight departments identified one or more provisions of their states' laws that would prohibit the sale of these policies, at least in certain markets. Five other departments responded that their states either had made or were contemplating some changes to their states' MSA laws, but that these changes were not necessary to allow the sale of high deductible policies and were contemplated for other reasons. Two were undecided about the need for any changes.

Legislative Process

State insurance departments are moving ahead rapidly in working with their governors' offices and legislatures to prepare legislation implementing HIPAA. As of the end of January, twenty-seven state insurance departments reported to us that the bill containing the department's proposals had either been completely drafted, or was close to completion. In some of these states the bill has already been introduced in the legislature. In the other twenty-three states, the insurance department's proposed legislation was not complete at the end of January, but virtually all departments reported that the process of preparing the legislation is underway. Obviously these numbers are approximate and are changing daily. But the process is moving rapidly in many states, and has begun in all states.

IV. INTERPRETIVE QUESTIONS

The NAIC Committee is in the process of drafting a letter to the three federal agencies charged with promulgating interim final regulations under HIPAA by April

1, 1997: the Departments of Health and Human Services (HHS), Labor, and Treasury. This letter will identify those issues raised by state insurance departments relative to HIPAA for which the NAIC Committee believes regulatory guidance would be helpful and appropriate. Issues within the letter are still under discussion by NAIC members. We will provide Committee members and other members of Congress with a copy of this letter as soon as it is available.

As a general matter, it is likely that this letter will raise the following issues, among others: the guaranteed issue requirement applicable to small group insurance carriers; the applicability of this requirement to certain types of multiple employer welfare arrangements; interpretive issues surrounding the application of HIPAA's provisions regarding preexisting condition exclusions; the application of the preemption clauses within HIPAA to certain types of state laws; rules relating to "creditable coverage"; policy form requirements under HIPAA's individual health insurance market requirements; and other issues relating to the states' jurisdiction over health insurers and their enforcement role under HIPAA. As I stated above, however, the extent to which such issues will ultimately be addressed in our letter, as well as the nature and scope of our comments, are still under discussion.

During the development of HIPAA, the NAIC consistently recommended the inclusion of significant state flexibility within this legislation. NAIC members, as a general rule, oppose any federal preemption of state laws regulating the business of insurance. However, the federal proposals that culminated in the enactment of HIPAA all included some degree of state preemption, although some proposals were more preemptive than others. When our comments were sought on these proposals, we attempted to provide constructive comments about the parameters of the proposal without ever endorsing the concept of preemption. We recognized that, as a matter of federal law, the states could not legislate reforms applicable to self-funded ERISA plans and we promoted the concept of extending portability and other reforms to these plans. We also recognized that, as a consequence, Congress appeared, at the least, to want to set minimum federal standards applicable to all health plans. In our comments, we always promoted the ability of the state legislatures and policymakers to go beyond whatever minimum federal standards were established with respect to insured plans, and to continue the states' ability to construct unique state approaches. We also worked very hard to help ensure that the states' role as the primary regulators of the business of insurance was not eroded by any federal proposal which would have given the states diminished authority over certain types of insuring entities. This effort is reflected in our numerous letters to Congress commenting upon several of the legislative proposals which led to the enactment of HIPAA. Several of these letters were written together with the National Conference of State Legislatures (NCSL). In addition, our position that the states should have maximum flexibility reflected the position also taken by the National Governors' Association (NGA) in many of its communications with Congress on legislation leading up to HIPAA.

The NAIC's approach to the federal regulatory process for implementing HIPAA is consistent with its earlier positions on proposed legislation and will seek to ensure that the regulatory process serves to preserve the states' authority under the legislation. In addition, we hope to offer our technical expertise as the nation's primary regulators of health insurance to recommend clarifying regulations in instances of legislative ambiguity or uncertainty. That is why our members will submit the letter I referred to earlier to the federal departments developing regulations.

V. THE FEDERAL RULEMAKING PROCESS

HIPAA provides for the joint development of regulations regarding HIPAA's requirements for the employer group health coverage market (relating primarily to portability, availability, renewability, and nondiscrimination) by the Departments of HHS, Labor, and Treasury. In addition, the statute accords primary federal responsibility regarding HIPAA's provisions relating to the individual health insurance market to HHS. Finally, HIPAA's provisions relating to the tax treatment of qualified long-term care insurance policies and MSAs are to be enforced by the Treasury Department.

Since the enactment of HIPAA, NAIC members and staff have met with representatives from the three federal agencies to express their interest in the federal rulemaking process and to inform them about NAIC activities to assist the states in the implementation of HIPAA. The meetings of the NAIC's P.L. 104-191 States Implementation Working Group have been open to the public and representatives from federal agencies have been present at many of these meetings. So far, the agencies have been receptive to NAIC concerns and have expressed interest in receiving our formal recommendations regarding the regulations in the near future.

The passage of HIPAA has presented the NAIC, as well as the federal agencies, with a delicate balance. The NAIC would like to do its part to assist the states and facilitate a cooperative working relationship between its member state officials and the federal officials, as well as among federal, state, and NAIC staff. However, with respect to the statutory requirements set forth under HIPAA, it is important that the federal agencies understand the NAIC Committee's understanding of key statutory provisions, particularly as they relate to state flexibility and enforcement authority.

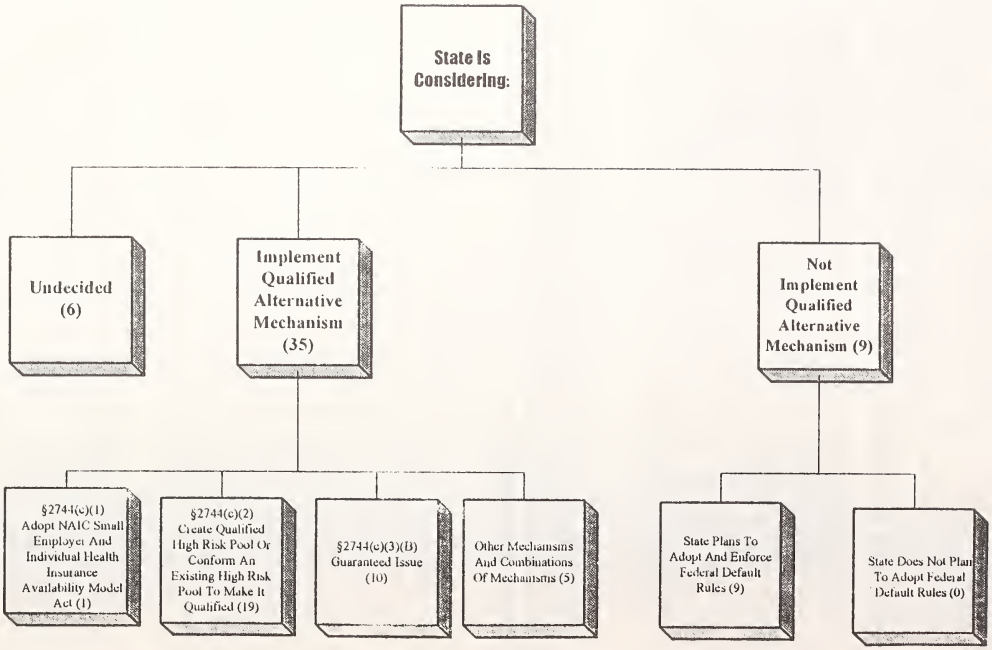
For example, the Health Care Financing Administration (HCFA) issued a notice in the Federal Register on January 13, 1997, concerning the provisions in HIPAA relating to "State Alternative Mechanisms." This notice appeared to set forth an "application and approval" type process which differed from the NAIC Committee's understanding of HIPAA's provisions. In our view, as set forth in a letter sent to Bruce C. Vladeck, HCFA Administrator, there is a strong statutory presumption in favor of state proposals, as long as they meet the statutory criteria. We hope to continue to communicate with all of the agencies regarding any guidelines or regulations they issue or are about to issue. We hope and anticipate that they will take our comments into consideration.

VI. CONCLUSION

Mr. Chairman, once again, the NAIC Committee and I thank you for the opportunity to testify today. We look forward to working with the 105th Congress on issues relating to HIPAA and health insurance generally. I would be happy to answer any questions you might have.

Individual Insurance Market

February 11, 1997



NAIC,
WASHINGTON, D.C. 20001-1512,
February 10, 1997.

Mr. BRUCE VLADECK,
Administrator,
Health Care Financing Administration,
Washington, DC 20201.

DEAR ADMINISTRATOR VLADECK: Thank you again for taking the time to meet with me and other members of the National Association of Insurance Commissioners ("NAIC") and our staff in early January. We appreciate the open lines of communication you have had with us since the enactment of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The NAIC, founded in 1871, is our nation's oldest association of state officials. Its 55 members are the chief insurance regulatory officials of the 50 states, the District of Columbia, and the four U.S. territories. The NAIC Special Committee on Health Insurance ("NAIC Committee"), on whose behalf we are writing this letter, was established by NAIC members to review federal health insurance initiatives affecting state insurance regulation and currently consists of 42 of the states' chief insurance regulatory officials.

As you recall, our last meeting was held immediately prior to the January 13, 1997 publication in the Federal Register of the "Notification Procedures for States Implementing 'Alternative Mechanisms' in the Individual Health Insurance Market" ("Federal Register Announcement") by the Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA). During our meeting, you had suggested the development of a "question and answer" document containing questions raised by state insurance regulatory officials and their staff once they had had time to review the final document. Subsequent to our meeting, and after discussion with other NAIC members, we decided that our concerns would be better reflected in a letter format rather than in the "Question and Answer" format originally discussed.

In this letter, we have identified the issues or questions raised by sections of the Federal Register Announcement, and then have included the NAIC Committee's comments on those issues.

Our primary concern is that the Federal Register Announcement, discussed in more detail herein, describes an "application and approval" process between the Secretary of HHS and states wishing to enact alternative mechanisms. In the NAIC Committee's view, HIPAA instead sets forth a process in which the Secretary of HHS only may disapprove mechanisms which fall to meet the statutory criteria. The distinction between approval and disapproval is very significant and more than semantic. It signifies a clear Congressional intent that the states be accorded the strong presumption that their proposed alternative mechanisms are "acceptable", if their Notices meet the statutory criteria spelled out in Section 2744(b)(1)(A) of the Public Health Service Act (PHSA). While some may see this as a subtle point, from the point of view of state officials, it is a major concern. It is very important that, as the states' governors and legislators move forward creating policy, and as the state insurance officials begin to implement this policy, there is a clear understanding on the part of HHS that HIPAA provides a statutory presumption in favor of the states whose notices comply with the law, and that HIPAA places the burden of proof upon the Secretary of HHS to demonstrate that a state's alternative mechanism is not acceptable under the statute.

Summary of the Federal Register Announcement

The Federal Register Announcement includes: 1) a summary of the statutory provisions under section 111 of HIPAA; 2) procedural guidance for states that intend to implement an alternative mechanism under section 111 of HIPAA; and 3) a description of the statutory provisions applicable in states that do not implement acceptable alternative mechanisms. From the onset, the Federal Register Announcement states that it does not "establish new policy or requirements."[1] The NAIC Committee appreciates this statement of intent and also wishes to ensure that the process by which the states notify HHS of their intent to enact an alternative mechanism, and HHS receives and responds to these notices, indeed comports with this goal.

The Federal Register Announcement begins by summarizing section 111 of HIPAA, which pertains to HIPAA's requirements regarding the individual health insurance market. Importantly, HIPAA's provisions relating to a state's notice of in-

[1]Notice, 62 Fed. Reg. 1768 (1997).

tent to implement an acceptable alternative mechanism include the following elements:

> A state is presumed to be implementing an acceptable alternative mechanism as of July 1, 1997 (the date upon which the federal "default" standards would otherwise become effective) if its chief executive officer, by no later than April 1, 1997, notifies the Secretary of HHS that the state has enacted or intends to enact "any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998 . . ."[2]
>
> A state's alternative mechanism only falls to comply with HIPAA if the Secretary of HHS makes a determination that a state's mechanism is not an acceptable alternative mechanism after permitting a state a reasonable opportunity to modify the mechanism or adopt another mechanism in a manner so that it may be an acceptable alternative mechanism, or to provide for the implementation of an acceptable alternative mechanism.[3]
>
> The statute also requires states to provide the Secretary with "such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) . . ."[4]

The combination of these elements of HIPAA's provisions relating to state submissions underscores a clear statutory construct: states that submit Notices of intent to enact mechanisms reasonably designed to be acceptable, along with such documentation as the Secretary may require, are under a heavy statutory presumption that their mechanisms are acceptable; and the Secretary's role with respect to state alternative mechanisms is strictly confined to one of disapproval in those narrow instances when a state mechanism is not, or is not implemented (or proposed to be implemented as), an acceptable alternative mechanism after the state has been accorded a reasonable opportunity to amend its mechanism.

HIPAA emphasizes this clear and confined role of the HHS Secretary in the provision entitled "Limitation on Secretarial Authority":

> The Secretary shall not make a determination under paragraph (2) or (3) on any basis other than the basis that a mechanism is not an acceptable alternative mechanism or is not being implemented.[5]

Many of the issues and comments highlighted below relate to and reflect the NAIC Committee's understanding and interpretation of the above-described provisions of HIPAA.

Issue 1: The Federal Register Announcement provides that states that choose to implement an alternative mechanism must submit a timely Notice to the Secretary of HHS "with sufficient documentation to enable us to determine whether it is an acceptable alternative mechanism."[6]

Comment: As summarized above, under the statute, the Secretary's authority is confined to disapproval of state mechanisms. HIPAA does not set forth an "application and approval" type of process.

Issue 2: HIPAA does allow for breaks in coverage that exceed 62 days.

Comment: The Federal Register Announcement states that an eligible individual must have an aggregate of at least 18 months of "creditable coverage," with no breaks in coverage that exceed 62 days.[7] PHSA Section 2701(c)(2)(A), as amended by HIPAA, states that "[a] period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage." The NAIC Committee interprets this provision to mean that a person could obtain coverage on the 63rd day of a gap period without losing "creditable coverage" under the Act because such a person would not have a gap in coverage for "all of" a 63-day period. Hence, it is our view that an individual's break in coverage could exceed 62 days (e.g. if it was 62.5 days) without losing the benefit of aggregation of coverage for the purposes of meeting the 18-month requirement to be an "eligible individual" under the individual market provisions of HIPAA.

Issue 3: The Federal Register Announcement states that the Secretary will suspend the statutory 90-day review period after which a state mechanism is presumed

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[2] PHSA §2744(b)(1)(A)(i), as amended by HIPAA.
[3] Id. at §2744(b)(2), (3).
[4] Id. at §2744(b)(1)(A)(ii).
[5] Id. at §2744(b)(4).
[6] Notice, 62 Fed. Reg. 1768.
[7] Id. at 1769.

approved if the Secretary notifies the State of her need for additional information or further discussions on its submission.[8]

Comment: The Federal Register Announcement's inclusion of a process for suspending the 90-day "time clock" is not explicitly spelled out in HIPAA. However, the Federal Register Announcement's discussion of this aspect of the notification process appears to be consistent with HIPAA's provisions as long as this aspect is carried out within reasonable parameters. The need to suspend the review clock would appear to be derived from the combination of the following two provisions of HIPAA: 1) PHSA Section 2744(b)(1)(A)(ii)'s requirement that the state provide the Secretary with such information as the Secretary "may require" to review the mechanism and its implementation or proposed implementation; and 2) the requirement within PHSA Section 2744(b)(5) which presumes a state plan to be acceptable unless the Secretary makes a finding to the contrary within 90 days from the date of submission. These sections set up an inevitable interplay between an express statutory provision which provides the states with some certainty, after a set time period, that they may presume their mechanisms to be acceptable, and the statute's allowance for Secretarial discretion to request "such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection."[9] It is our understanding and hope that any suspension of the 90-day time clock will occur only in instances when the state's notification package truly did not include the documentation clearly required in order for a state to document that its proposed mechanism is "reasonably designed" to meet the requirements of that subsection of HIPAA and that any such suspension immediately will end as soon as the state has provided such information.

Issue 4: Documentation Required under HIPAA Relating to State Notices of Intent to Enact an "Alternative Mechanism."

Section VI(B) of the Federal Register Announcement sets forth the requirements for documentation by the states intending to enact alternative mechanisms. Importantly, the Federal Register Announcement states that that section is not intended to set forth a checklist of criteria. Our comments recognize this caveat. Nonetheless, several statements within this section appear to set forth the possibility that HHS, through its review process, will expect, if not require, a level and depth of documentation that does not appear to be contemplated or required by HIPAA. While many statements throughout the Federal Register Announcement clarify that these examples are illustrative and that the need for such documents will depend upon the nature of a state's proposal, we would nonetheless like to highlight some areas of possible disagreement with the Federal Register Announcement as they relate to the NAIC Committee's understanding of the statute's requirements with respect to alternative state mechanisms.

Issue 4(a): Initial state notifications of intent to enact alternative mechanisms only need to include documentation regarding their proposed implementation.

The Federal Register Announcement characterizes the Secretary of HHS's responsibilities vis-a-vis states' submissions of Notices of intent to implement an acceptable alternative mechanism in the following manner:

> "We must, however, be able to determine whether the mechanism will be both designed and enforced in a way that will ensure that eligible individuals are given the required access to insurance coverage . . . Our main concern is that the State submission show the analysis and the reasoning behind the design of the proposed alternative mechanism, and a reasonable assessment of the likelihood that the mechanism will achieve the legislative objectives . . . The submission must include sufficient information to provide us with a reasonable basis for concluding that the proposed alternative mechanism meets the requirements described in section VI.C. of this notice."[10]

The relevant statutory provisions specifically require the states to provide "the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection."[11] The statute also states that the notification must inform the Secretary "that the State has enacted or intends to enact . . . any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998 . . ."[12] Importantly, we read these provisions to contemplate that, with respect to notifications relating to states' intention

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[8] Id. at 1774-1775.
[9] Public Health Service Act §2744(b)(1)(A)(ii).
[10] Id. at 1772.
[11] PHSA §2744(b)(1)(A)(ii).
[12] Id. at §2744(b)(1)(A)(i).

to implement alternative mechanisms received by HHS by April 1, 1997, there only is a statutory expectation that the state provide sufficient documentation to demonstrate that its mechanism is "reasonably designed" to be acceptable as of January 1, 1998 and that, in this context, the Secretary will consider information concerning proposed implementation but will not require information relating to its actual enforcement or "likelihood [of achieving the] objectives." Such a requirement both would be premature and outside the statutory requirements for such notification packages. We presume that the Federal Register Announcement's reference to information relating to enforcement was referring to proposed enforcement with respect to submissions made by April 1, 1997. If not, we would ask that the actual review Process reflect such an understanding.

The NAIC Committee understands that the statute provides for Secretarial review of actual enforcement every 3 years after a scheme is in place.[13]

Issue 4(b): HIPAA does not require, nor could it be construed to require, that states that submit their notifications of intent to enact an alternative mechanism by April 1, 1997 need to call an emergency or special legislative session in order to benefit from the presumption in the statute that state plans which meet the requirements of the relevant sections of HIPAA are presumed to be acceptable.

Comment: The Federal Register Announcement includes a recommendation that states include information concerning the state legislative calendar, including a "description of the authority and procedures it follows for calling a special or emergency legislative session, if these exist.[14]

We presume that the request for a description of the authority and procedures for calling a special or emergency legislative session in the states does not reflect an understanding on the part of HHS that the calling of such a session is contemplated or required under the statute. If the Secretary of HHS were to make such a request subsequent to a preliminary determination by the Secretary that a state's mechanism was not acceptable, it would appear to violate the statute's requirement that the Secretary, subsequent to such a preliminary determination "shall permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) . . . or to provide for implementation of such a mechanism."[15] Hence it is our view that, particularly with respect to the initial notifications received prior to April 1, 1997, HIPAA does not require states to call special or emergency legislative sessions.

Issue 4(c): The Federal Register Announcement recommends the submission of several types of state laws and regulations which, at least upon first consideration, do not appear to be clearly relevant to HHS' statutory task to determine if a state's proposed alternative mechanism does not meet the statutory criteria.

Comment: The Federal Register Announcement states that laws and regulations that could be critical to an adequate analysis under the Act include the following: "Medical underwriting and rating restrictions; [r]estrictions on preexisting condition exclusions, [g]uaranteed issue requirements; [s]olvency requirements."[16] As you are aware, HIPAA's requirements relating to rating in the individual market are minimal, do not apply in all instances, and provide for significant state and carrier flexibility. Within the section on state alternative mechanisms, the relevant provisions are, in Section 2744(c)(2)'s definition of a "qualified high risk pool", a requirement that premium rates be consistent with standards within the NAIC's Model Health Plan for Uninsurable Individuals Act and that, with respect to states enacting an "other mechanism described in Section 2744(c)(3)" ("other mechanism"), the mechanism must provide for "risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers."[17] It is our understanding that a state would only need to provide information regarding laws on medical underwriting and rating restrictions to the extent such' information is relevant to a demonstration that its proposal meets these requirements or the statute's prohibition on the imposition of preexisting condition exclusions for eligible individuals. In addition, the Federal Register Announcement provides that a "State should describe in detail how the risk associated with serving all anticipated eligible individuals would be spread under the mechanism and how the additional cost associated with serving this new population would be sub-

[13] Id. at §2744(b)(1)(C).
[14] Notice, 62 Fed. Reg. at 1772.
[15] Public Health Service Act §2744(b)(2)(B).
[16] Notice, 62 Fed. Reg. at 1772.
[17] "Public Health Service Act §2744(c)(3)(A).

sidized."[18] This request deviates in a subtle but important way from the relevant statutory provisions and appears to require something beyond the statutory criteria.

Furthermore, it is not clear to the Committee what the relevance of solvency requirements would be to a demonstration that a state mechanism meets HIPAA's requirements. HIPAA does not include any regulation of carrier solvency and in fact underscores the preservation of the states' authority. to regulate insurance under ERISA (contained in ERISA section 514(b)) through its statement in Section 2743(a)(2): "Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans." Later in the Federal Register Announcement, in example 2, there is reference to concern for the financial stability of an existing risk pool that appears to be entering a "premium death spiral."[19] If the Federal Register Announcement's reference to, and HHS's desire to review, solvency requirements relate to information concerning such a scenario, it would be helpful if the nature of this request was so narrowed.

In addition, the description of the type of information that a state "may submit" regarding a proposal to improve an existing risk pool goes beyond what would appear to be necessary in order to demonstrate that a risk pool could serve the population of eligible individuals as required by the statute. The Federal Register Announcement mentions, as an example, a state which included within its Notice "in considerable detail, analyses of the projected revenue, subsidies, and financial condition of the pool under the proposed law. State B also specifies how HIPAA eligible individuals will be able to enter the risk pool without causing a break in coverage."[20] It would appear more in keeping with the statutory requirements if HHS expected that such a state would include a description of its proposed remedy to ensure that the pool will cover eligible individuals pursuant to the statutory requirements. For example, if a state was not sure of the precise size of the population of eligible individuals (which may be very likely for reasons which we elaborate upon in our comment to Issue 4(e) herein), it would appear that a proposed scheme which included funding flexibility to account for increased need would suffice without necessarily having to provide precise revenue and financial condition information.

Issue 4(d): Relevance and Availability of Information regarding the "Characteristics of the Existing Individual Market."

Comment: The Federal Register Announcement recommends the inclusion of information regarding a state's individual market in a state's notification and provides the following examples of what this information might include: "[A] description of the policy forms currently available in the individual market in the State; numbers of policies held under each form; current population of the State; estimated percentage of that population currently covered under group plans or coverage other than individual coverage; and estimated uninsured population."[21] Some of this information is not directly required under the statute and may be too burdensome to compile for the relative additional information it might provide. In some instances, this information may not be available and could not readily be available. For example, with respect to policy forms, in some states insurers may have filed literally thousands of policy forms. It would appear that a state's standard of review for policy forms, rather than a description of such numerous forms, would be sufficient under the statute, if required at all. In addition, with respect to any estimates of the percentage of the population currently covered under group health plans, it is important to remember that a significant portion of such a population are covered under self-funded ERISA governed plans which are outside the scope of state regulation and state data collection efforts. Importantly, in a July 1995 report, the U.S. General Accounting Office (GAO) noted the difficulty of obtaining accurate information regarding the number of persons covered under ERISA-governed self-funded plans.[22] Hence, neither the federal nor state government at this time are able to provide precise information on enrollment in group plans. Finally, the critical question is whether "federally eligible individuals" will be covered under the alternative mechanism in the manner required by HIPAA. Any information not responsive to that question would appear to be irrelevant.

Issue 4(e): Relevance and Availability of Information Regarding "Projected Market Impact of the Alternative Mechanism."

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[18] Notice 62 Fed. Reg. at 1773.
[19] Id.
[20] Id.
[21] Id.
[22] Employer-Based Health Plan's: Issues, Trends and Challenges Posed by ERISA GAO, July 1995.

Comment: In this section, the Federal Register Announcement asks the states to include an estimate of the number of individuals to be served and how the mechanism will meet the statutory requirements.[23] Once again, it is not clear that a state needs to have these numbers at hand in order to create a mechanism and put together a notification that will meet the statutory requirements, as long as it is flexible enough to meet the demands that arise. In addition, the extent to which some of this information is relevant to determinations concerning alternative mechanisms, if at all, will depend at least in part upon the extent to which the proposed alternative mechanism includes a public program, such as a state high risk pool. For example, particularly for mechanisms that are privately-based, but probably for other public mechanisms as well, it is not clear that a state would need to prove that the mechanism will "serve the needs of the affected population"[24] (rather than "cover eligible individuals as required by the statute") nor is cost information for such coverage necessarily relevant for the purposes of submitting a Notice of intent with respect to a privately-based alternative mechanism.

Issue 4(f): The Federal Register Announcement includes a list of the "[g]roups whose relative size may be large enough to have substantial impact on the number of eligible, as well as ineligible, individuals . . ."[25]

Comment: It is not clear whether the Federal Register Announcement is suggesting that states submit this information. If so, it is curious because several of the programs mentioned are federal programs and, once again, it is not clear that the statute would require the states to submit these types of statistics and documentation.

Issue 5: Standard of Review. The Federal Register Announcement states that "[t]he statute clearly requires us to make a substantive determination whether a mechanism is an 'acceptable alternative mechanism' that meets all of the requirements set forth in the statute."[26]

Comment: As noted earlier, the statute provides the Secretary with authority to determine that a state's mechanism is not acceptable. There is no approval process set forth in the statute.

Issue 6: Time Frames: The Federal Register Announcement states that HHS will review each State's submission to determine whether it addresses each of several specified requirements, including whether the mechanism provides access to coverage for all eligible individuals within "federal time frames."[27]

Comment: HIPAA's requirements with respect to the availability of coverage in the individual market include certain deadlines, yet also include the possibility for some flexibility for the states which choose to implement an alternative mechanism. We presume that the Federal Register Announcement's reference to the "federal time frames" recognizes this flexibility. As noted in the beginning of the letter, states which submit notification of their intent to enact legislation to provide for the implementation of a mechanism "reasonably designed" to be an acceptable alternative mechanism as of January 1, 1998 by April 1, 1997 are presumed to be implementing an acceptable alternative mechanism as of July 1, 1997 (the effective date for the other individual reforms) or 90 days after the submission of the Notice, if earlier. We construe the phrasing "reasonably designed" to provide the states with some flexibility if, for reasons not foreseen at the time of submitting the Notice, the state's mechanism is not in place exactly on January 1, 1998. Even more significantly, Section 2744(b)(2)(B) of the Public Health Service Act requires that, in instances where the Secretary makes a preliminary determination that a state's mechanism is not acceptable, the Secretary provide the state with "a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) in a manner so that may be an acceptable alternative mechanism or to provide for implementation of such a mechanism." This section sets forth no clear dates or time limits for such activity other than the requirement that the opportunity afforded the states be "reasonable."

Obviously, we understand the importance of providing federally-eligible individuals with the protections under the law in a timeframe as close to the statutory goal of January 1, 1998 as possible. Nonetheless, we want to clarify the fact that the "federal time frames", particularly in instances when a state's initial submission receives such a preliminary determination by the Secretary, include some flexibility.

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[23] Notice, 62 Fed. Reg. at 1773.
[24] Id.
[25] Id.
[26] Id.
[27] Id.

Issue 7: The Notice contains the statement that "[t]he [NAIC] Availability and Portability Models also contain residency requirements that cannot be applied to HIPAA-eligible individuals."[28] We disagree that a state cannot impose a residency requirement, but we would agree that any such residency requirement cannot impose a minimum period of residency.

Comment: The NAIC Availability and Portability models contain a definition of "eligible person" which states: "'Eligible person' means a person who is a resident of this state who is not eligible to be insured under an employer-sponsored group health benefit plan." (Emphasis added.) (See Section 3K of the Portability Model and Section 3M of the Availability Model.) The term "eligible person" is obviously a critical term and is used throughout both models. The Portability Model also contains a definition of "recently insured individual" which requires such an individual to be "a resident of this state." These definitions do not, however, define "resident" or set a minimum period of residency.

In contrast, the NAIC's Model Health Plan For Uninsurable Individuals Act does contain a definition of "resident," defined to be "an individual who has been legally domiciled in this state for a period of at least thirty (30) days." (See Section 3N of the Uninsurable Model.) We would agree that a state may no longer impose such a minimum period of residency. The NAIC's P.L. 104-191 States Implementation Working Group has therefore recommended that the definition of "resident" in the Uninsurable Model be amended to delete the 30-day requirement for eligible individuals under HIPAA.

There is a distinction between a residency requirement and a minimum period of residency. A state can impose a residency requirement which can be fulfilled without an individual's having to satisfy any minimum residency period. We do not think that HHS can prohibit a state from setting such a requirement, as long as the requirement does not impose a time period that could potentially bar a resident from participating in the state's alternative mechanism, if that individual qualifies under federal law. There are a number of reasons why states would limit their insurance reforms to state residents. First and foremost, a state can only legislate for the residents of that state. Second, if a state's general revenues subsidize the high risk pool or other alternative mechanism, then beneficiaries should be limited to residents, who in most cases will be state taxpayers. Third, if a state were required to make its alternative mechanism available to any U.S. citizen, there would be very complex legal and practical implications. Would this mean that a resident of New York City could choose among the options offered by New York, New Jersey, and Connecticut? We therefore do not agree that states are prohibited from establishing any residency requirement for individuals who are eligible for the protections established by P.L. 104-191 in the individual market. We would only agree that a minimum period of residency is not acceptable.

We would respectfully urge you, in your review of state Notices of intent, to recognize that a minimum residency period is probably not acceptable; however, state alternative mechanisms only need to serve residents of each state.

Once again, we appreciate the open dialogue we have had with you and your agency staff and look forward to its continuation. We hope that you will consider our comments as you move forward with implementation of HIPAA. Please do not hesitate to call any of us if you wish to discuss this or other related matters further.

Best regards,

JOSEPHINE MUSSER,
President, NAIC.

PREPARED STATEMENT OF CHRIS PETERSEN

Mr. Chairman and Members of the Committee, I am Chris Petersen, Vice President of the Health Insurance Association of America (HIAA). HIAA is a trade association which represents approximately 225 of the nation's health insurers, who in turn provide health coverage for tens of millions of Americans.

The Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, was a major and in many ways an unprecedented action in the health benefits field. We applaud the work of your committee and staff in developing this legislation. HIAA was very involved in this legislation through its entire process, providing Congress with our positions on the implications of the various issues.

Subsequent to the enactment of HIPAA, HIAA has offered our support and comments to the three regulatory agencies, the Department of Labor, the Department of Health and Human Services and the Department of Treasury, responsible for administration of the law. We have been impressed with the dedication and efforts

[28] Id. at 1774.

with which the agencies have approached their responsibilities. HIAA has also worked closely with the National Association of Insurance Commissioners (NAIC), whose staff has put in countless hours in advising the individual state regulators concerning the implications of the legislation.

HIAA shares in what we believe are the common goals of the Congress, state legislators, the NAIC, and the insurance community. These goals are: the appropriate and efficient implementation of the federal law; clarity in the regulations so all entities providing health benefit plans are playing under the same rules; and continued regulation of insurance at the state level.

HIAA supports the general construction of the law as to relative federal/state responsibilities, regulation and enforcement. The Act is based on the assumption that, as it pertains to insured plans, the states will assume the primary responsibility for enforcement. This state role will, of course, be subject to federal review, particularly if the states are not found to be substantially enforcing particular provisions. We believe that this is appropriate and builds on the strong structure of state regulation of insurance.

As you are aware, in many cases, changes in existing state laws are required for the states to satisfy the federal requirements. Different changes are needed for the different markets: the individual market, the small employer market, and the large employer market. The need for state law changes exists in virtually all, if not all, of the 50 states. Many of these changes will be technical in nature, but nonetheless each state must take legislative action.

One particularly critical area regarding needed state legislative changes involves the individual insurance market where, in order for state and not federal regulations to apply, state governors must certify by April 1 of this year their intention to adopt an "acceptable alternative mechanism" to provide for portability in the individual market. We believe it is in the public interest that the states do assume this regulatory responsibility and will be looking to the federal regulations and actions of the federal regulators to be consistent with this goal. Our position is that, consistent with the Act, states should be given maximum flexibility with as little federal control and expense as possible in assuming responsibility to assure compliance in the individual market.

Having said that, we expect to continue to work satisfactorily with the federal regulatory agencies to that end. In turn, we are urging that regulations are consistent with our overall goal of state enforcement on the most flexible basis consistent with the Act.

As I mentioned, we are most satisfied with our work with the federal agencies to date. They have given us ample opportunities to meet with them and to present our concerns and positions both orally and in writing. We respect the regulatory development process that they are carrying out.

In our discussions with the federal regulators, we have focused primarily on two types of issues. First, there are a set of issues which relate to the very scope and breadth of the Act and, for the insured plan component, its potential impact on state regulation. Into this category, we have placed the overall issue of allowed state flexibility in assuring there is substantial compliance with the Act and the certification of coverage requirements on health plans.

The second set of issues regards potential unintended consequences depending upon regulatory interpretation of the Act's requirements. Into this category, we have placed issues relating to when insurers are required to Offer coverage, issues surrounding the Renewability of Individual Insurance Coverage for Individuals Eligible for Medicare and issues surrounding Short-Term Limited Duration Health Insurance.

The following are detailed comments on these issues:

I. STATE FLEXIBILITY AND STATE ENFORCEMENT OF THE ACT

Enactment of the Health Insurance Portability and Accountability Act represents a significant departure from the sharply divided insurance regulatory roles between federal and state government. In part, HIPAA enacts federal standards for access, portability, and renewability of health insurance for insured group health plans and issuers of such plans. Prior to HIPAA, states regulated the business of insurance while federal regulation was limited to plans sponsored by large employers and unions, with the exception of private Medicare supplemental insurance ("Medigap"). Because private Medigap products wraparound the federal Medicare program the Congress chose to establish minimum federal standards for state regulation of such products. States are required to enact, apply, and enforce standards which are "equal to or more stringent than" the Medigap federal rules. See Social Security Act §1882.

A. Enforcement Only

HIPAA's federal-state structure is unparalleled and represents a case of first impression in the area of regulating the business of health insurance. Unlike the federal Medigap standards, however, under HIPAA states are not required to enact, apply, and enforce equal or more stringent standards. HIPAA only provides that states must "substantially enforce" the explicit statutory provisions of HIPAA applicable to health insurance issuers to avoid federal enforcement and to achieve a minimum level of uniformity on "portability" regulation. See Public Health Service Act §2745. States will also be required to enforce any additional detailed rules issued by the federal agencies in regulatory directives responding either: (1) to a Congressional request in the law for more guidance; or (2) where the Secretary believes additional guidance to be necessary or appropriate1 to carry out the provisions of HIPAA. See Public Health Service Act §2792.

Primary State Enforcement. Even though HIPAA's enforcement requirement is permissive rather than mandatory because it provides that each state may require that issuers meet the requirements of the Act, the intent is clear that in the case of health insurance issuers, the federal government is not directed to establish an enforcement bureaucracy. See Public Health Service Act §2722. Rather, the Secretary of HHS is to rely upon the states and to reserve federal authority for only instances of substantial enforcement failure on the part of the states. Accordingly, federal enforcement in the case of state regulated health insurance issuers is a secondary "fallback" or "back stop" authority.

Limited Federal Fallback. The exercise of federal authority is itself limited to instances of where, with respect to a single provision of the Act or many provisions of the Act, a state has substantially failed in its enforcement. See Public Health Service Act §2722(b)(1). Thus, if a state has failed to substantially enforce one requirement of the Act, the Secretary may only exercise federal enforcement of that one provision. It appears that the Secretary would not be permitted to use the failure of one provision as a reason to federally enforce all of the provisions of the Act. Also, use of the limiting phrase "substantial", to describe a state's failure, also limits federal enforcement to circumstances of, for example, repeated or deliberate non-enforcement by a state, and not isolated instances of administrative inertia or lapse.

Meaning of "Substantially". Because Congress did not define the term "substantial", it must be construed according to its plain meaning. The term generally means a matter of real worth and importance; of considerable value; actually existing; real; not seeming or imaginary; not illusive; solid; true; something worthwhile as distinguished from something merely nominal; synonymous with material. The term "material" is generally defined to mean of real importance or great consequence. See Webster's Third New International Dictionary at 2280 (1981). Accordingly, a state's substantial enforcement failure under the Act would seem then, to be defined as a willful departure from enforcing the essential terms of the Act. Where a state has, in good faith performed its duty to enforce the material particulars of the Act, it will be found to be substantially enforcing the Act.

Determination Procedure. The Secretary must "make a determination" that a state has failed to "substantially enforce" a provision (or provisions) of the Act. In view of the magnitude of the consequences of "making a determination" of such a failure, it is incumbent upon the Secretary to establish a process for making that determination. Such a process must involve a written notice to a state describing the basis upon which a "substantial" failure has been alleged. An adjudication process would appear to be the most appropriate forum for hearing a dispute over such determination, and subject to judicial review. See 5 U.S.C. §554. Also, once a determination is made that an individual state has substantially failed to enforce a provision of the Act and the Secretary exercises federal enforcement authority, the duration of that authority appears to last only in so far as the state continues in its failure. The law does not provide that, once the Secretary assumes authority, it is defacto permanent. This would seem to require an opportunity and a process for rehearing or appeal by a state after federal authority is assumed.

State Enforcement Options. In devising their enforcement strategy, the states will determine what cost-effective mechanisms will achieve the necessary "substantial" enforcement. Conferees even deleted an explicit requirement in the Senate version of the bill that states develop and file an enforcement plan with the Secretary. See S. 1028, 104th Cong., 2d Sess. §202 (1996). HIPAA does not provide authority for the federal government to question the wisdom of a state's choice of an enforcement mechanism so long as the state satisfies the "substantial" enforcement standard. The Act allows each state the flexibility to adopt whatever sanction or remedy it believes necessary to carry out the purposes of the legislation, through the state insurance regulatory structure (including an Insurance Department or, where applicable, Department of Corporations). Congress intends for the enforcement provisions

to build upon and maintain the current division of enforcement authority between the states and federal government. See Senate Rpt. No. 156, 104th Cong., 1st Sess. At 32 (1995) (report to accompany S. 1028).

Among the mechanisms available for state enforcement are criminal and civil penalties, cease and desist orders, injunctions, removal of officers and directors, fines, revocation of (or refusal to renew) licenses. States also impose statutory and regulatory requirements on policy content, policy form approval or disapproval, market practices, and complaint monitoring. Another mechanism, which would appear on its face to be acceptable, is for a state to adopt the very same approach authorized by the Congress for use by the Secretary to enforce the Act including: liability of designated parties; amount; exceptions for a prior record of compliance, or where the failure was not discovered exercising reasonable diligence, or where failures are corrected in a timely manner. See Public Health Service Act §2722(b). That approach imposes a civil money penalty upon health insurance issuers equal to $100 for each day with respect to the failure to meet a provision of the Act.

Incorporation by Reference. In enacting its enforcement mechanism, the state statute or regulation that sets forth provisions for imposition of penalties, for example, could perhaps incorporate by reference that the penalties are "imposed for violations of Title All of the Public Health Service Act (and regulations)." Some states have taken the approach of simply incorporating federal laws by reference, for example, as in the Medigap regulation area. See NAIC, Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, Section 1 0.C. (referencing Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990). Other states, however, may find Constitutional constraints imposed with respect to "incorporating by reference" laws not otherwise enacted by the state. In such case, a state may need to enact the relevant text of HIPAA into state law in order to be able to "substantially enforce" its provisions.

B. Narrow Preemption.

Enforcement of HIPAA will require states to enact appropriate laws and regulations to set forth the standards to be enforced, either by reference or by enacting detailed provisions. HIPAA explicitly supersedes state law which "differs" with respect to only the rules of section 2701 relating to preexisting condition exclusions. See Public Health Service Act §2723(b)(1). The Act also provides limited exceptions to the rule which permits states to enact specified and different standards applicable to certain, limited aspects of the preexisting condition exclusion rules. See Public Health Service Act §2723(b)(2). HIPAA intends supplementary state regulation and narrowly preempts other state laws which 'prevent application" of a federal requirement. Otherwise, where state law does not impede the federal law, a state may establish, implement, or continue in effect any standards and requirements. See Public Health Service Act §2746. In this regard, the Congress explicitly intends the "narrowest" preemption. See H.R. Rept. No. 738, 104 Cong. 2d Sess. At 205 (1996) (conference report to accompany H.R. 3103).

C. Conclusion.

HIPAA sets forth a new structure for regulating the business of health insurance. Federal requirements for health insurance issuers relating to portability, accessibility, and renewability are established, however, these rules are intended to be enforced by the states and not the federal government. Accordingly, the federal role is limited to ensuring that a state substantially enforces the Act. The state's role is framed on the one hand by the preferred "enforcement only" rule, and on the other by the narrow preemption rule that requires enforcement of preexisting condition exclusion rules which do not "differ" from the Act and which also accords states an ability to establish, implement, or continue any other laws and regulations that do not "prevent application" of the federal requirements under HIPAA. This framework clearly establishes a regulatory structure that accords substantial flexibility and deference to the states.

II. CERTIFICATION OF COVERAGE

HIAA believes that regulations should require certifications based upon uniform data elements developed under federal regulations, and that the regulations should include a model certification form to be used on a voluntary basis.

HIAA has a number of concerns related to the certification requirements—pertaining both to the issuance of certifications and to the receipt of certifications when individuals exercise their portability rights under the Act.

Issuance of Certifications in the Group Market

The Act, in Section 701(e)(1)(A), requires group health plans and health insurance issuers to provide individuals, at specified times, with certificates that document prior coverage. The Act further indicates, in Section 701(e)(1)(C), that a group health plan is deemed to have satisfied this requirement if the health insurance issuer provides the required certificate.

In group coverage, particularly large employer coverage, the employer (or other plan sponsor), generally maintains records of employee enrollment in the group health plan, including which coverage option the employee has elected (where more than one option is offered), and including whether the employee has self-only or family coverage. Frequently, the health insurance issuer(s) providing coverage does not receive positive enrollment information from the employer. Instead, when eligibility verification is required, the issuer seeks eligibility confirmation from the employer.

Conversely, in connection, with small employer plans, generally the health insurance issuer maintains records of covered individuals, both employees and dependents, which records may not be available, particularly on a historical basis, with the employer.

On both a transitional and forward-going basis it is important that, with respect to a given group health plan, there be a clear delineation of responsibility for issuance of certificates and that this responsibility not rest simultaneously with both the plan and an issuer.

In the large employer situation, it would be appropriate for regulations to allow this responsibility to rest with the employer involved or plan, unless otherwise agreed to between the employer or plan and the issuers. This may, for example, be totally consistent with the employer's administration with respect to COBRA notices.

Again, conversely, in the small employer area, it would be appropriate for regulations to allow certification responsibility to rest with the issuers involved unless otherwise agreed to between the employer or plan and an issuer. Where health insurance issuers must rely on certifications by small employers, recordkeeping by small employers must allow issuers to verify the information and must assure information is available for verification over periods of time.

To assure that entities issuing certifications have the necessary information, particularly with respect to dependents, regulations should be based on the assumption that individuals exercising rights under the Act are responsible to provide employers, plans and/or issuers with information and verification regarding employee and dependents covered and coverage periods. Regulations should recognize the magnitude of the overall certification process, regarding imposition of penalties during a transition period.

Receipt of Certifications in the Group and Individual Markets

Regulations should address protections for group health plans and health insurance issuers in the event of incorrect certification, whether caused by poor record keeping or purposeful incorrect information.

III. DEFINITION OF "OFFERING COVERAGE"

HIAA believes that, for purposes of PHSA Sections 2741(a)(1) and 2711(a)(1), "offering coverage" means "actively marketing new coverage," and does not mean "actively marketing new coverage and/or renewing existing coverage." We believe that public policy considerations, legislative intent and statutory/legal construction all lead to the conclusion that the narrower definition was intended.

Using a more expansive definition of "to offer" has substantial public policy ramifications. The broader definition forces carriers into markets in which they no longer issue products. Many carriers continue to renew policies, based on statutory or contractual requirements, even though they are not issuing new policies in that market segment. For instance, some carriers have individual policies on their books and continue to renew those policies even though they "have not been in the individual market" for several years. Forcing carriers back into the individual market simply because they are renewing policies would leave carriers with only two options: reenter a market within which they no longer wish to sell products or cancel all existing individual policies under Section 2742(c)(2). We are fearful that many carriers would opt for the latter; thus resulting in market disruptions and in significant numbers of individuals losing their coverage. This would be a substantial hardship for many of these individuals since they do not receive portability protections under HIPAA. These individuals would likely become uninsured. Similar problems would also occur in the small group market. Clearly this was not the legislative intent.

HIAA also believes that an analysis using statutory construction and "plain meaning of the language" leads to the conclusion that offering coverage should not include the renewal of coverage. Black's Law Dictionary defines offer to mean "to present for acceptance or rejection . . . to make a proposal . . ." It also suggests that the reader "[s]ee also Bid; . . . Issue; . . ." This definition speaks more in terms of issuing or actively marketing coverage. HIAA, in its nationally recognized educational text book on individual insurance, defines offer to mean "[t]he initial proposal." Additionally, the text book states "[t]he application for insurance is always an integral part of the offer process." Once again, a definition that excludes the renewal of coverage.

The National Association of Insurance Commissioners (NAIC), in its model laws on individual and small group insurance reforms, also supports the notion that offering coverage should not include renewing coverage. The NAIC's Small Employer and Individual Health Insurance Availability Model Act requires that carriers "actively offer to individuals all health benefit plans it actively markets to individuals . . ." Section 7.B.(1) (emphasis added). Similar language also applies to carriers in the small group market. See Section 7.A.(2). In revising its models to conform with HIPAA, the NAIC did not amend the cited language.

Other provisions of HIPAA also support the idea that the renewal of coverage should not be included within the definition of "to offer coverage." Section 2713 sets forth the kinds of information that carriers must disclose with the offering of any health insurance coverage to a small employer. Normally, carriers are required to disclose this type of information when they issue a new policy. See also Section 2701(c)(3)(B) pertaining to the alternative method of crediting of coverage at time of offer. Since preexisting condition exclusions are not imposed at renewal, health insurance issuers would only use the alternative methods at time of issue e.g., offer.

Unfortunately, the Act does not define offer and it appears the word might have different meanings in various provisions of the law. However, HIAA believes that for purposes of Sections 2701(a)(1) and 2741(a)(1) offer was intended to mean only actively marketing new coverage. We base our conclusion on the public policy and legal arguments set forth above.

IV. RENEWABILITY OF INDIVIDUAL INSURANCE COVERAGE FOR INDIVIDUALS ELIGIBLE FOR MEDICARE

Section 2742 of Title 1, Subtitle B of the Health Insurance Portability and Accountability Act ("HIPAA") relates to required guaranteed renewability of certain comprehensive individual health insurance coverage. That section requires guaranteed renewability of coverage except in the following cases: nonpayment of premium; fraud; termination of all coverage offered by an issuer; movement outside of a service area by a network-covered policyholder; or an individual ceases membership in a bona fide association.

Because the law is silent with respect to cases where a person covered under an individual health insurance policy becomes eligible for Medicare some believe that issuers must renew such coverage for Medicare beneficiaries. A significant number of persons with individual health insurance coverage maintain such insurance until they become Medicare beneficiaries. Following state and NAIC-endorsed provisions, health insurance issuers today routinely terminate individual health insurance policies upon the policyholder's attainment of Medicare eligibility due to age.

It is our view that HIPAA does not address this issue simply because there is no individual insurance market in the over age 65 population. Carriers may not sell comprehensive major medical insurance to this population group and so do not need to renew coverage. Prior to the enactment of HIPAA, the NAIC Individual Health Insurance Portability Model Act provided for an exception to guaranteed renewability in the case of attainment of eligibility for Medicare due to age. Our view is also consistent with traditional state regulation of individual insurance. State regulation has always held that an acceptable policy contract provision of an individual major medical policy would be that the coverage terminates when an individual became eligible for Medicare by reason of age. This was a contractual provision that the individual understood when they purchased the policy.

Congress determined that, for persons age 65 and older individual health insurance coverage would be provided through Medicare, and that private coverage would be supplementary. It is important as a matter of public policy that Medicare beneficiaries not pay premiums for private major medical health insurance coverage that truly duplicates Medicare. Certainly Congress did not intend this result. Accordingly, issuers should not be required to renew coverage that is duplicative of Medicare. In addition, absent an exception from guaranteed renewability by the states

for persons attaining Medicare eligibility by reason of age, premiums will increase for individual coverage, thereby adversely affecting availability and affordability.

It is our view that states have the authority to address this particular issue, and that the Act's preemption language would not preclude a state from adopting or continuing a provision permitting an exception to guaranteed renewability by reason of attainment of eligibility for Medicare due to age. This is because HIPAA specifically permits states to establish, implement, or continue in effect any standard or requirement that does not prevent application of a requirement of the federal law.

Congress explicitly intended state flexibility with respect to this issue. The report accompanying the Senate version of HIPAA states that nothing in the legislation shall be construed to prevent states from establishing, implementing, or continuing in effect either: health insurance standards and requirements not prescribed in the legislation; or standards and requirements that are related to the issuance, renewal, or portability of health insurance that are consistent with and not in direct conflict with the federal rules. See S. Rpt. 156, 104 Cong., 1st Sess. at 31 (1995). See also H.R. Rept. 738, 104th Cong., 2d Sess. at 205 (1996).

In supplementing the federal law, the prior NAIC model provision does not impede, circumvent, interfere, or conflict with any of the federal guaranteed renewal provisions. Such a state law would apply uniformly without regard to any health status-related factor of covered individuals; and such individuals would be covered under an entitled federal health insurance plan. Such a state law also appropriately promotes the Social Security Act's nonduplication requirement without going so far as to specify that a health insurance policy duplicates Medicare.

Some concern has been raised with respect to the use of the word "only" which precedes the listed exceptions to the guaranteed renewal requirement. However, reading this word "only" to mean that a state may not establish, implement, or continue in effect a standard or requirement which "differs" from Section 2742's provisions ignores the more narrow preemption rule applicable to Subtitle B. See Section 2746(a). State laws under the "Individual Market Rules" are constrained only so far as such laws "prevent application" of the federal rules.

By contrast to the individual insurance rules in HIPAA, Congress specifically provided for broader preemption of certain state laws with respect to the group portability requirements. The Act specifically provides that federal law supersedes any state law which differs from Section 2701 (relating to preexisting condition exclusions) with only limited exceptions for specific and more generous preexisting condition exclusion and coverage break periods under state law. See Section 2723(b).

In sum, we believe that states have the authority and are accorded flexibility under section 2742 to enact a supplementary provision permitting an exception from the guaranteed renewability requirements based only on attainment of eligibility for Medicare due to age. Because some have misread the intent of Section 2742, we have respectfully requested that the interim final regulations expected to be published on April 1 clarify that states have the authority to adopt or continue such an exception.

V. SHORT-TERM LIMITED DURATION HEALTH INSURANCE

The federal (fallback) requirements for guaranteed availability of coverage for "eligible individuals," in Section 2741(a)(1), could have the effect of requiring a health insurance issuer that provides only short-term, limited duration health insurance coverage, and no other type of individual coverage in a given market, to guarantee issue individual health insurance coverage to "eligible individuals." We believe this was not intended by Congress.

First, the definition of individual health insurance explicitly excludes short term, limited duration insurance. See PHSA §2791(b)(5). Second, under Section 2741(a)(1), arguably such a health insurance issuer would not be allowed to offer short-term, limited duration policies (the only products it currently offers) to eligible individuals, because such coverage is not individual health insurance.

Finally, Congress does not intend to require issuers to create policy forms for offer in the marketplace except those already actively marketed and which meet the Act's other requirements. See PHSA §2741(c).

We believe this issue must be clarified in the April 1 regulations. Specifically, in defining a "health insurance issuer" for purposes of the requirements of Section 2741, the regulations must specify that issuers offering only short-term limited duration insurance are not subject to the guaranteed availability requirements. This would appear to be an exercise of the Secretary's authority under Section 2792 to issue "necessary and appropriate" regulations.

As indicated above, these and other issues have been placed before the agencies with regulatory responsibility, and we are hopeful that our positions will be given due consideration.

HIAA appreciates the opportunity to present this information to the Committee and looks forward to providing the Committee with any further information it may require.

Prepared Statement of Susan E. Nestor

Mr. Chairman, the Blue Cross and Blue Shield Association (BCBSA) appreciates this opportunity to comment on the implementation of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

The implementation of the new law is an immense task. The agencies responsible for developing regulations must grapple not only with a large number of complex and unfamiliar issues, but they must do so in a very short period of time. Blue Cross and Blue Shield applauds the Department of Labor, Treasury, and Health and Human Services for the efforts they have made to solicit comments from affected groups and industries.

Blue Cross and Blue Shield Association staff has been included in a series of meetings with the Department of Health and Human Services' staff for the purpose of providing Blue Plans' perspective on each element of P. L. 104-191. Marc Thomas, Director of Contractor Planning & Management Division, has taken on the complex challenge of leading the Department work group and is to be complemented, along with the other group participants, for a thoughtful and gracious effort.

In particular, the agencies' task is particularly difficult as the issues to be addressed in the forthcoming regulations are both complex and unfamiliar to federal regulators. Traditionally, the substantive regulation of the health insurance market has been the responsibility of State government. The law clearly intends that the States will continue in this role.

Although the federal legislation is relatively concise, the brevity of the legislation also means that the regulations will need to clarify the substantive requirements of the Act. While the industry has been studying the Act since it was signed into law last August 21, the regulations providing much of the needed clarification will become available only on April 1 of this year—just nine weeks before the requirements of the law go into effect.

To better understand the operational issues facing Blue Plans, BCBSA has conducted ten regional meetings across the country and met with over 800 Plan, broker, and agent representatives. During these meetings, Plans identified a broad range of issues and a number of questions that will need to be addressed quickly.

Blue Cross and Blue Shield Association believes clarification is required regarding the following issues: I. Certificates of Coverage; II. Guaranteed Renewability of Coverage to Individuals; III. Multiple Employer Welfare Arrangements (MEWAs); IV. Coverage Offered Through or by Associations; V. The Small Group Market; and VI. Administrative Simplification.

I. CERTIFICATES OF COVERAGE

Possibly no issue has been the cause of so much uncertainty and elicited so much comment from Blue Plans as the requirement that health plans issue certificates of coverage. This is because:

the law may be interpreted as requiring automatic issuance of certificates to every individual in every circumstance, even when there is no use of the certificate and it creates a bureaucratic burden for heath plans;

health plans are required to include information on certificates that health plans do not collect nor have any reliable mechanism to solicit, (e.g., dependent information, C.O.B.R.A., employer waiting periods) necessitating brand new business functions and information systems unrelated to providing insurance to individuals and groups;

health plans must begin to issue certificates so quickly after regulatory notice—less than four months from now (June 1)—that it will be extremely difficult for plans to properly modify business operations and information systems to meet the laws deadline; and

the requirements for issuance of certificates are not clearly laid out in the Act itself.

Summary of HIPAA Requirements

The basic goal of the Act can be simply stated: to assure individuals moving to a new group health plan do not face pre-existing condition waiting period if they

have adequate prior coverage. To facilitate this goal, the Act requires all health plans (including Medicare, Medicaid, and high risk pools) to issue certificates of coverage automatically whenever any subscriber—and their dependents—terminate coverage. Consumers can then use those certificates to demonstrate prior coverage.

Questions Related to Certificates of Coverage

While the notion behind certificates of coverage is commendable, in practice the requirements pertaining to certificates are proving to be more complex. In addition, the vast majority of people will never need to use a certificate of coverage, only those individuals who have health conditions and are entering a health plan that imposes pre-existing condition waiting periods need to demonstrate prior coverage. Even consumers in this category may not need certificates. After all, many states have had portability requirements similar to HIPAA for years and they have not needed to require issuance of certificates of coverage. As result of this, the expense associated with automatically issuing certificates to subscribers and/or dependents would have no real value or benefit to most consumers.

In addition to the questionable value of automatically issuing certificates versus issuing only upon request, the Act is unclear on the situations in which a certificate of coverage should be issued:

Must health plans issue a separate certificate for each person covered under a policy? Many plans do not maintain records on dependents covered under a family policy and therefore are unable to generate certificates of coverage for dependents.

Must health insurance issuers provide information on employment history? The information to be included on a certificate must include information that is not generally available to an insurer. For example, insurers generally do not have the date of hire for employees of companies that have a waiting or probationary period that new employees must satisfy before becoming eligible to enroll in the company's health benefit plan. The insurer only knows the date on which the individual enrolled in the health plan. However, for purposes of the Act, the waiting period is not considered a break in coverage—and must therefore be recorded on a certificate. Other information that is not known to the health plan concerns the employee's eligibility for COBRA benefits. HIPAA's requirement that individuals elect and exhaust COBRA benefits is the primary mechanism to prevent adverse selection in the individual market.

Must certificates be issued when an employer switches carriers? Because employers relentlessly seek the best value for their benefit dollar, they frequently switch from one carrier to another. When they do, their employees are issued new insurance cards identifying the new carrier. Health plans should not be required to issue a certificate of coverage to individual employees because they remain covered under the employer's health benefit plan—even though the plan is offered by a new company.

Must plans issue certificates when an employee switches between plan options? Many group health plans provide their members with several options, for example an HMO option, a PPO option, and a traditional option. Each year a person has the opportunity to switch between plan options. It would be pointless to require the issuance of a certificate of coverage each time a person switches health plans since the employee remains covered under the employer's health plan.

BCBSA recommendations related to certificate of coverage

Clarify that health plans are not required to automatically issue certificates of coverage, particularly in circumstances when the individual has no use for a certificate. Instead, clarify that certificates will be issued upon request, when individuals need documentation of prior coverage.

Clarify that health plans do not need to issue individual certificates for dependents—only one for the family.

Clarify that the health plan issuer is required to provide only that information related to the individual's history of coverage under the plan. This would not include information related to the individual's employment history (such as eligibility waiting periods or COBRA eligibility).

Clarify that either health plans or employers should issue certificates, but not both. Blue Cross and Blue Shield does not believe that the authors of the law intended to require the issuance of duplicate notices. The Act specifically indicates that an employer is not required to issue a notice if the employer's health insurance issuer provides certifications, but the converse does not apply.

Clarify that certificates need to be issued only after an individual loses eligibility for benefits under an employer's (or other group's) health benefit plan. A certificate should not be required when an individual switches between health plan options offered by an employer.

II. RENEWABILITY OF COVERAGE TO INDIVIDUALS

The best known of HIPAA's provisions are those regarding portability into the individual market. HIPAA establishes certain minimum standards for insurance sold to individuals (i.e., non-group health plans) that are designed to prevent the loss of coverage when a person leaves a group health plan and enters the individual market. A lesser known individual market provision addresses the renewability of coverage.

Summary of HIPAA requirements

HIPAA requires all health insurance issuers making coverage available in the individual market to renew all coverage sold to individuals with the following exceptions: the individual fails to pay their premium; the individual commits fraud against the health plan; the health plan ceases to offer the plan (in which case special rules apply); the individual moves outside the service area of the health plan; or the individual ceases to be a member of the association through which the plan was issued.

The law makes no explicit exception to the renewal requirement for individuals who become eligible for Medicare benefits. However, in other aspects of the legislation it clearly treats Medicare eligibles as distinct from those generally in the individual market. Many states have adopted guaranteed renewal requirements in their individual market and allow health plan issuers to nonrenew or cancel coverage when an individual becomes eligible for Medicare benefits.

Questions related to the individual market

It was clearly not the intention of Congress to require health plans to renew coverage that duplicates Medicare benefits. In fact, HIPAA amended the Medicare statute to strengthen and clarify the federal prohibition of the sale of coverage that duplicates Medicare benefits. However, without some clarification, health plans may be in a position of having to renew coverage that duplicates Medicare benefits.

BCBSA recommendations related to the individual market

Health plans should not be required to renew coverage when an individual becomes eligible for Medicare benefits.

III. MEWAs

During the 104th Congress, several proposals were made to use federal law to encourage the formation of multiple employer purchasing arrangements. These proposals were dropped from the version of the bill that was signed into law last August. Throughout the HIPAA debate, it was always the intention of the primary sponsors that the same federal standards should apply to all types of health plans—including plans offered by Multiple Employer Welfare Arrangements. Nevertheless, in the months since the passage of the bill, some have claimed that the bill does not require MEWAs to comply with the portability, guarantee issue, renewability, and other standards established by the Act. Blue Cross and Blue Shield Association believes that it is crucial for Congress and the Administration to resolve this question by clearly and unambiguously extending the same requirements to MEWAs that apply to other issuers of health plans.

Summary of HIPAA requirements

The only discussion of MEWAs in the Act occurs in the new section 703 of ERISA, added by section 101 of HIPAA. Section 702 of ERISA requires all coverage offered by MEWAs and multiemployer plans to renew coverage for all employers participating in its plan except for certain specified conditions. There is no indication elsewhere in the Act that health plans offered by MEWAs would be exempt from any of the Act's requirements.

Questions related to MEWAs

Health insurance issuers are, under the Act, required to offer coverage to any small employer. Similarly, the Act requires bona fide associations that offer health plans to issue coverage to any member of the association regardless of health status. Multiple Employer Welfare Arrangements must be held to the same standards as bona fide associations.

BCBSA recommendations related to MEWAs

MEWAs must be subject to same requirements as bona fide associations with respect to issuance of coverage to members. The federal law and regulations should not permit any MEWA to pick and choose, based on the health status of employees, the employers to which they will offer coverage.

IV. COVERAGE THROUGH ASSOCIATIONS

In many parts of the country, both professional and other associations make health plans available to members. These associations can offer both individual and group health plans. The unique characteristics of these association plans is recognized by HIPAA. Unfortunately, the nature of the association business can blur the distinction between group coverage and individual coverage. As a result, the regulations will need to be carefully structured, and will need to identify: the requirements that apply to associations that offer coverage to individuals; the requirements that apply to associations that offer coverage to groups; and, the requirements that apply to health insurance issuers that offer coverage both to associations and directly to groups and individuals.

Summary of HIPAA requirements

HIPAA provides for special treatment of bona fide association groups. HIPAA defines a bona fide association as an organization that: has been in existence for at least 5 years; was formed for purposes other than obtaining insurance; uses membership criteria that are not related to health status makes health insurance coverage available to all members regardless of health status; does not offer health insurance coverage except in connection with members of the association; and meets the requirements of State law.

Questions related to association groups

Do individuals leaving a plan obtained through an Association have prior group coverage or prior individual coverage for purposes of HIPAA?

BCBSA recommendations regarding association groups

Consumers who purchase coverage from an Association through their employer should be treated as having prior group coverage. Those consumers purchasing direct-pay coverage from an Association should be treated as having individual coverage.

V. GROUP INSURANCE

The principal purpose of HIPAA is the establishment of standards for group health plans.

Summary of HIPAA requirements

HIPAA requires all group health plans to extend coverage to every otherwise eligible member of the group. An employer may continue to offer benefits selectively to classes of employees, but these classes may not be based on any factor related to health status. Thus, an employer can offer benefits to full time, but not to part time, employees.

In addition, an employer must also provide an opportunity to enroll in the health plan to every employee when certain "qualifying events" occur. These qualifying events include the addition of a dependent through marriage, birth or adoption, the loss of other group coverage for a spouse or dependent, etc.

Questions related to group insurance

The law also makes provision for the imposition of a longer pre-existing condition waiting period for late enrollees, but does not clearly indicate whether an employer is required to cover a late enrollee at any time throughout the year or just during a specified annual open enrollment period. We believe allowing individuals access to year-round late enrollment periods would create adverse selection problems by encouraging individuals to wait to enroll until they experience health problems.

BCBSA recommendations regarding group insurance

There should be no requirement that a health plan have late enrollment periods. A plan should be able to limit enrollment to an annual "open enrollment" period and special enrollment periods tied to qualifying events such as marriage or the birth of a child.

VI. ADMINISTRATIVE SIMPLIFICATION

A major, if less publicized, component of HIPAA was the establishment of federal requirements governing electronic transmission of health care data between and among health plans and providers.

Summary of HIPAA requirements

Subtitle F of Title II provides for the establishment of federal standards for electronic data transactions and requires health plans to conduct transactions that comply with these standards when requested by another "person".

Questions related to administrative simplification

The Department of Health and Human Services is making a concerted effort to solicit broad input from all affected groups and industries as they develop regulations implementing the new federal standards for administrative simplification. There are a number of questions that need to be addressed quickly: Will the standards be applied to transactions between business partners, or will non-standard transactions that are designed to meet the business requirements of the partners be permitted? In other words, does the law prohibit non-standard transactions under all circumstances?

BCBSA recommendations related to administrative simplification:

Clarify that there is no prohibition of non-standard transactions "intra-Blue Plans" such as the Blue Plans national network that assures customers have "seamless" insurance from one state to another.

The standards that are adopted should be implemented not earlier than February 1999, but the Department should make every effort to definitively indicate which standards will be adopted in advance of that date. This will permit plans adequate time to implement the standards without mishap.

VII. CONCLUSION

In conclusion, Mr. Chairman, we again commend the agencies for their work on this monumental task with such impending deadlines. We look forward to working with Congress and the Administration to assure the smooth regulatory implementation of HIPAA. We also urge the Congress and the agencies to address areas of the law that could be interpreted in a way that contradicts the overall intention of the 104th Congress when it passed HIPAA. If essential technical law changes should be made as soon as possible if a regulatory solution is not adequate.

Prepared Statement of Gail Shearer

Thank you for inviting Consumers Union[1] to testify today on the implementation of the "Health Insurance Portability and Accountability Act" (HIPAA). I would like to begin by commending the Members of this Committee for all of your work on health care reform—both the work that led to HIPAA and your earlier efforts to enact national health care reform. We are grateful to Chairman Jeffords for his leadership on the issue of lifetime caps, and we want to take this opportunity to thank Senator Kennedy for his leadership in working to get a bill passed last year, resisting a full-scale medical savings account program, and successfully including important protections for MSA consumers in the final bill.

Thanks to HIPAA, hundreds of thousands, maybe a few million consumers will avoid onerous pre-existing condition exclusions and will be able to get—and keep—health insurance that would not have been available without the bill. In a world where comprehensive health care reform has been a long-standing unfulfilled dream, there was celebration when the bill was enacted. But I believe that there is consensus—even among its strongest supporters—that HIPAA was a modest bill. It should be viewed as a first step—not the last step—toward health care reform.

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

We commend this Committee for holding this important hearing to explore implementation issues. My testimony will address several areas where there are early warning signs of problems that need the attention of Congress. Before addressing these specific concerns, I would urge this Committee to set an agenda for its work during the 105th Congress that establishes HIPAA as a first step in a series of measures that will move this nation toward universal, high quality health care coverage. We urge you to set as a high priority legislation that will extend coverage to all children in this country, legislation that will establish substantial, badly needed consumer protections for all enrollees of managed care plans, and the establishment of a blueprint for additional measures that will ultimately lead to comprehensive health care reform. And we urge you to do all that you can to preserve the structural integrity of the Medicare and Medicaid programs—two programs that have provided years of health care protection for millions of elderly and poor consumers.

This is the appropriate time for the Senate Labor and Human Resources Committee to begin its oversight function. As I will describe below, there is already concern that while HIPAA holds the potential to help many consumers, it also has the potential to create new problems for others. The best way to minimize the problems is to get all appropriate federal agencies—and the Congress—working to make sure that ambiguities of the law are clarified and to take steps to prevent unscrupulous players in the market from exploiting consumers in order to line their own pockets.

In my statement, I will address the following issues: portability provisions, long-term care insurance; medical savings accounts; niche insurance products sold to seniors; and criminalization of asset divestiture.

FIVE KEY IMPLEMENTATION ISSUES

Portability of insurance coverage. Perhaps the most important improvement that HIPAA makes in the health insurance market is the "portability" protection it provides consumers who are able to remain continuously insured. Consumers who switch jobs, from one employer who offers health coverage, to another that also offers health coverage, will not face new pre-existing condition periods, during which they would have been ineligible for certain health benefits. Individuals who work for an employer offering health coverage will be assured that they will not be denied coverage or charged higher premiums because of their health status. Individuals who leave the work force will be able to keep some sort of health insurance (provided they can pay the premium).

We understand that the purpose of this hearing is not to rewrite the legislation, but nevertheless it is important that I point out that there are millions of consumers who will not benefit from the protections against pre-existing conditions: any consumer who can not afford to continue to pay for their coverage when "between jobs" is likely to face pre-existing condition waiting periods when and if they become eligible for a new employer's health plan. Also, there is no assurance that premiums will be affordable for consumers under the bill. In addition, the bill has exceptions.

For example, there is an exception in Section 2721 for state and local governments, that will keep certain people such as non-federal public employees from benefitting from the portability protections. (Public employees in states with state legislation may be protected, but public employees in the other states—roughly half—could find that they are without portability protections if their state or local government employer chooses not to provide the protections.) This exception will be a surprise to those individuals who find they are caught in a loophole that denies them protection.

Working with the bill as written, we have several concerns.

First, we believe that consumers' expectations about the protections that are offered by the bill may be out of line with the reality of the bill's impact. There has been considerable exaggeration about the scope of the protections—and consumers, understandably, are expecting the bill to solve more problems than it will. An important role, then, for the government is to educate consumers about their rights under the bill as well as the time frame for the bill's implementation. Consumers are going to need assistance—from the federal government and from their state government—in navigating this new health insurance marketplace.

Second, we have serious concerns about how the insurance industry will turn the bill's provisions for state flexibility (in choosing what mechanism to use to make individual insurance available to people with prior group coverage) to its advantage, with serious implications for consumers. We are hearing reports that insurance companies are working to actually undermine and overturn state regulations and laws that offer consumers greater protections than those of HIPAA. For example, we have heard that insurance carriers are working behind the scenes to undo the rating

reforms that Colorado had enacted into law prior to enactment of HIPAA. In some states, the insurance industry is working hard to achieve "minimal" compliance; if they succeed, many consumers will not benefit from "portability" because the policies offered by insurers will be unaffordable since only high risks will be covered by them. Over the past 60 years, Consumers Union has been alarmed at the clout that insurance companies have before the United States Congress. Equally disturbing—but perhaps not as visible to those of us inside the beltway—is the influence that the insurance industry has in state legislatures. With the voice of the consumer quiet in comparison simply because we can't match the resources of the insurance giants, the risk is that the consumer will once again be the victim of special interest politics, a potential unintended consequence of HIPAA.

Therefore, the Congress should monitor state response to HIPAA. If, as we fear, momentum grows for states to overturn hard fought consumer protections of the health insurance market (e.g., market reforms that define groups as being size 1 to 50 and rating reforms that lower premiums for higher risks), then we would urge Congress to establish federal standards that clearly preempt state laws in order to protect consumers. We do not believe that Congress intended that HIPAA be an excuse for industry to strong-arm states into rolling back established state policies that go further than the "minimums" in HIPAA—for example, protections that help make health insurance affordable to self-employed groups of one or to people who are high risks.

Long-term core insurance. The HIPAA provision that extends a limited amount of tax deductibility to premiums paid for long-term care insurance[2] also raises serious implementation concerns. On January 16, 1997, Consumers Union filed comments on the. long-term care issues with the Department of Treasury.[3] Consumer Reports has published reports on private long-term care insurance policies that clearly show that shopping for a long-term care policy is very confusing and filled with traps for the consumer. In June 1991, the Consumer Reports article "Gotcha: An Empty Promise to the Elderly?" identified numerous consumer problems in this market including: the absence of built-in inflation protection; the absence of nonforfeiture benefits (and high lapse rates); variation in definitions of benefits; agent incentives to sell policies without considering the long-range interests of policyholders; and the potential for premium increases.

Unfortunately, HIPAA makes the long-term care insurance market even more complicated and adds a new trap for consumers: HIPAA establishes a new, relatively restrictive definition for long-term care policy benefits for policies that are to be "tax qualified." What this means for informed consumers is that they must choose between (1) buying a comprehensive long-term care insurance policy that offers benefits for home care, and nursing home care, "triggered" by a range of possible disability levels, and (2) buying a long-term care policy that provides benefits only under the most extreme cases of disability.

In this market, it is very hard to be an informed consumer. While the Department of Treasury is expected to release guidance for consumers in April, consumers are being barraged with sales pitches from insurance companies already. In addition, insurance companies are using the tax preference issue as a marketing tool—but at this point, the insurance companies are not in a position to even judge whether the policy will truly be tax deductible for the consumer. There was mention in the Wall Street Journal that, due to the tax incentive, some companies are reporting that sales of long-term care policies had already increased by 50 percent. An internet posting[4] lists the "fact" that "[l]ong-term care insurance is tax deductible," without mentioning that individuals' premiums are deductible only to the extent that they (and other health costs) exceed 7.5 percent of income, and that only "qualified" policies are tax deductible.

The inconsistency between the long-term care insurance provisions of HIPAA and state laws and regulations means that there is confusion all around. Clearing up this confusion and then providing useful information to consumers should be a high priority for state and federal regulators alike.

In our comments, we urged the Department of Treasury to make use of the existing network of senior health insurance counselors—participants in the Insurance Counseling and Assistance Programs (ICA)—to help communicate with consumers

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[2] Consumers Union opposed the tax preference for long-term care insurance premiums because we believe that limited funds that are available to pay for long-term care should be targeted to help low and moderate income consumers, rather than create a new (and potentially very costly) tax preference that mostly helps the rich.

[3] Letter from Gail Shearer, Consumers Union, to Donald G. Lubick, Acting Assistant Secretary for Tax Pclicy, January 16, 1997.

[4] http://jvm.com/future-care/

who are trying to sort out the complexities of the long-term care insurance market. Each state now has an insurance counseling and assistance program, which trains volunteers to assist seniors with their health insurance needs—choosing a Medicare supplement insurance policy, choosing a long-term care insurance policy, or filing Medicare claims. These programs have a ready-made network of hundreds of people who are anxious to receive accurate information about the new tax preferences for long-term care insurance. We urge all the federal departments charged with implementing HIPAA to use these programs to communicate with seniors.

Medical savings accounts. Perhaps the most controversial issue that surfaced during the enactment of HIPAA was medical savings accounts. During consideration of the bill, Consumers Union expressed strong concern about the potential for medical savings accounts to fragment the health insurance market, and drive up premiums for those people who prefer to remain in the traditional (relatively low deductible) health insurance market. In the end, HIPAA included a demonstration MSA program of limited size, and, thanks in large part to the work of Senator Kennedy, many crucial consumer protections that help make the high deductible insurance policies that are paired with MSAs more comprehensive in coverage than they would have been in the absence of the protections.

One of our implementation concerns involving MSAs relates to the measuring of the extent to which relatively healthy people are drawn to MSAs. During the Congress' consideration of HIPAA, we pointed out that many objective studies predict that widespread adoption of MSAs in the health care marketplace will eventually lead to substantial increases in premiums in the traditional, low-deductible market. HIPAA requires the Comptroller General to contract with an outside group to study the effects of medical savings accounts in the small group market—in particular, the effects on selection, health costs, use of preventive care, consumer choice, and scope of coverage of high deductible plans. I can not emphasize enough the importance of careful study design if this critical task is to be done properly.[5] It is crucial that the study carefully consider the health status of families enrolled in MSAs with the health status of families not in MSAs. Strong Congressional oversight—as well as the insistence that the study meet the legislatively established schedule—will be crucial.

A second area of concern is the strict adherence to the cap on the size of the demonstration program. There has been significant publicity about the introduction of MSAs—with a federal tax deduction—into the health care market. Once again, consumers' expectations with regard to MSAs are high. The Department of Treasury issued a notice (Notice 96-53) on November 29, 1996, that explained various elements of the MSA pilot project. The notice raised several important implementation issues. First, the notice indicated that MSA enrollees will be in charge of deciding how the MSA account funds are to be used, apparently with little (if any) oversight. In other words, based on this notice, individuals with MSA accounts will have a free hand to determine whether a particular expenditure should be considered eligible for coverage under the MSA. The notice does not indicate what records individuals should' maintain. It does not indicate that MSA distributions will be subject to IRS audit. We urge the Department of Treasury to offer guidance to consumers on how to determine whether an expenditure should qualify for MSA coverage. In addition, we believe that it would be prudent to establish the same kind of verification system that exists for other health care expenditures that qualify as tax deductible. Without a system in place, it is possible that MSA funds will be used for purposes that should not truly be considered as health care expenses, leaving MSA enrollees with the prospect of having depleted accounts just when health care expenses occur.

Another area where we believe Department of Treasury guidelines will be important is in the area of investment options for MSA accounts. One of the reasons that Consumers Union has opposed medical savings accounts is the fear that money will be diverted from the pool of funds available to cover health care expenses and into savings accounts for the healthy. If consumers can invest their MSA account funds in the stock market, then we believe that this will intensify the perception (and the reality) that MSA programs are about investment—not paying health care costs. The Wall Street Journal recently reported that, as we feared, some insurers and banks are already marketing MSA accounts as a means of long-term investing.[6]

Another area of concern with MSA implementation involves the enforcement of the 750,000 cap in the number of MSAs allowed under the demonstration. In its November 29, 1996 notice, the Department of Treasury did not provide assurance that

[5] See also Katherine Swartz, PH.D., "Medical Savings Accounts and Research," inquiry, Fall 1996.

[6] Nancy Ann Jeffrey, "New Medical Plans for Small Businesses Carry Investment Options, but Also Risks, Wall Street Journal, January 3, 1997.

it will carefully monitor and verify the number of MSA enrollees who are "previously uninsured." The bill makes it clear that to be considered "previously uninsured," consumers could not have had comprehensive insurance coverage for a six-month period before the start of high-deductible coverage. If people who actually had insurance are counted as "previously uninsured," then the cap is likely to be exceeded. In addition, the notice raises the possibility that there will be considerable time lags between the time that the maximum is exceeded, the time the notice to the public that the cap limits have been reached issued, and the time that sales of new MSAs actually end. To the extent that limits are exceeded, more accounts than Congress intended will be opened.

Niche insurance products sold to seniors. Another area that bears careful oversight by Congress is the private health insurance market for seniors. In 1990, as part of OBRA-90, Congress successfully overhauled the senior health insurance market. The result was a simplified market (with ten standard benefits packages) and substantial reduction in the sale of wasteful, duplicative policies to seniors. Unfortunately, HIPAA turned back the clock on these reforms by making it easier for insurance companies to sell policies to seniors that they simply don't need if they have Medicare coverage and one medigap policy. HIPAA changes the definition of what constitutes "duplication" in this market, and now allows insurance companies to sell multiple, overlapping policies to seniors as long as all policies pay benefits. The bill also guts the disclosure requirements that were developed by the National Association of Insurance Commissioners (and approved by the Secretary of Health and Human Services) to warn consumers against possible wasteful duplication. The disclosures will soon read: "Some health care services paid for by Medicare may also trigger the payment of benefits under this policy." Instead of a warning against duplication, consumers will get a marketing pitch saying that they could get extra benefits.

As a result of this provision, companies that market policies duplicating Medicare and Medicare supplement insurance will again be able to sell numerous policies of little value to consumers. For example, hospital indemnity insurance, cancer insurance, and intensive care insurance are policies designed to prey on seniors' fears. Companies are marketing these policies on the internet, and the insurance press is writing about these growing markets. Expansion of sales of such "niche" products to the elderly are inevitable, as a result of this provision of HIPAA, and are not in the consumers' interest. We urge you to monitor carefully the impact of these changes on the health insurance market for seniors, and take further steps as appropriate.

Criminalization of asset divestiture. Section 217 of HIPAA included a provision that established criminal penalties (including jail) for people who "knowingly and willfully disposes of assets" in order to gain eligibility for Medicaid. This provision came as a last minute surprise to many health policy analysts who participated in the legislative process leading to HIPAA. The intent of Congress was clear: to provide a strong incentive against the hiding of family assets that should be used to cover long-term care costs. While we share the objective of Congress to preserve Medicaid funds for the truly needy, we are deeply troubled by the prospect of HIPAA leading to the transfer of elderly nursing home residents from their nursing home to prison.

Whether or not Congress chooses to retain the criminalization provision, it is important that you understand how some people are responding to it. In Arizona, lawyers are playing on the fears of the elderly to drum up business. An ad ran in the Phoenix Daily News-Sun that said:

> "You Only Have Until December 31st, 1996
>
> To Avoid making the Mistake That Could Toss You in Jail . . . Congress' Sneaky New Law Is the Most Vicious Attack on Retirees Yet!"

The toll free number published in the full text of the ad led to a message, recorded in a woman's voice, that offered a warning about the "Grandma goes to jail law." This ad stirred up alarm in the senior community. It made seniors fear that (as the ad indicated) simply making gifts to children or grand-children, or adding an adult child's name to a checking account (to ensure access if something happened to you) could be a felony leading to imprisonment. Unfortunately, HIPAA raises the possibility that seniors will be scared inordinately, and may deter them from some prudent financial transactions. We believe that Congress should clarify that felony charges, steep fines, and imprisonment will not apply to the average citizen who is merely trying to assure their bills will be paid in the event that they become incapacitated.

RECOMMENDATIONS

In response to our concerns, we recommend that the Congress:

1. Monitor the implementation of HIPAA by the states. If states react to HIPAA by rolling back stronger state laws, or if "minimal compliance" fails to provide affordable insurance coverage, then Congress should consider stronger legislation that reduces state flexibility.

2. Monitor the implementation of HIPAA by federal agencies. Federal agencies should provide information that consumers can use about their new portability rights, long-term care insurance, and medical savings accounts. They should be required to meet the timetables established in HIPAA for submission of key reports such as the impact of MSAs on the health insurance market. They should work closely with the Insurance Counseling and Assistance Program (ICA) to educate seniors about health insurance, especially long-term care insurance.

3. Monitor developments in the health insurance marketplace. If marketing abuses abound, if new niche product markets (especially for seniors) grow, then Congress should take corrective action quickly.

4. Establish a counseling program—modeled on the successful Insurance Counseling and Assistance Program (ICA) for seniors—to help consumers navigate the health insurance markets and help them benefit from the protections in HIPAA.

Holding this hearing is the first step toward successful implementation of HIPAA. Thank you for providing us the opportunity to testify. We look forward to working with this Committee in continuing to work toward a health care marketplace that serves the needs of consumers.

Prepared Statement of Terry Humo

INTRODUCTION

Mr. Chairman, and members of the Committee, I am Terry Humo, a senior attorney and assistant vice president at the firm of Sedgwick Noble Lowndes, an international employee benefits consulting firm based in Memphis, Tennessee. I am testifying today on behalf of the Association of Private Pension and Welfare Plans (APPWP—The Benefits Association) where I serve on the association's Board of Directors and chair its task force on the implementation of the Health Insurance Portability and Accountability Act of 1996.

APPWP is the national association of firms and individuals concerned about federal legislation and regulations affecting employee health and pension benefit plans. APPWP's members include Fortune 500 companies, managed care plans, and consulting and actuarial firms. The association's member companies and organizations sponsor or provide services to health and retirement plans covering more than 100 million Americans.

I appreciate this opportunity to present our views to the Committee today on the Health Insurance Portability and Accountability Act (HIPAA). We welcome the Committee's interest in the implementation issues related to this important piece of legislation that will soon affect the lives of more than 145 million working Americans and their families who have health care benefits that are voluntarily sponsored by employers. My statement today includes a summary of APPWP's position on the portability bill and on other incremental health reform measures which the Committee may soon consider. I have also provided our views on several implementation issues on health insurance portability identified by an APPWP task force whose members have been reviewing the legislation in detail.

PORTABILITY OF COVERAGE AND FUTURE HEALTH REFORM EFFORTS

The enactment of legislation to promote the portability of health benefits was clearly one of the most significant achievements of this Committee last year and one of the defining acts of the 104th Congress. As we now turn to the implementation stage, employers and health plans will need a flexible regulatory approach, clear guidance and ample time if the Act is to reach its promise to improve the lives of millions of working Americans as they move from job to job. Employers also have a keen interest in what happens next on the incremental health reform road and whether the portability bill will be followed by measures that support our employment based health care system or which penalize it and inhibit its success.

During the consideration of the portability act last year, APPWP and the large majority of employer sponsors of health benefit plans considered the legislation as a positive step forward because its objectives were viewed as compatible with market-based strategies to reform the health care system. As large purchasers of health care services, employers have been a dominant force in reshaping the health bene-

fits landscape by making it more responsive to consumer needs and satisfaction, more focused on delivering quality and appropriate care, and more understandable and rational for all of us who depend on health care services. If implemented appropriately, portability legislation can add a new dimension to these private market efforts by helping individuals maintain continuous health coverage, especially for a workforce which has become increasingly mobile.

There are several lessons to be drawn from the experience in enacting health portability legislation last year, but in our view the most important lesson is that successful government sponsored reforms in the health care field ought to work with, and not against, the voluntary, employer-based health care system. While much has been written over the past few years about the problems and gaps in our nation's health care system, there is a fundamental and continuing public interest in maintaining the strong and committed presence of private employers in the voluntary offering and financing of health care services for their employees. The private financing of health services through the workplace remains the single most important source for health care coverage for most Americans.

Promoting the voluntary sponsorship of health plans by employers involves making some important choices about the future direction of health policy and the next steps down the road of incremental health reform. For example, rather than enacting benefit mandates that only drive up health care costs and gradually take more employers and employees out of health coverage, private and public health purchasers could be encouraged to work together to develop the information needed to make better, more informed health care decisions to achieve the objectives of high quality and appropriate health services. Similarly, individuals could be encouraged to assume more responsibility for their personal health and well being by supporting successful employer on-site wellness initiatives and health promotion programs and by extending the benefits of these programs to other workplace settings. Most of all, to maintain coverage levels as high as possible, we should recognize the benefits to our economy and to each of us as individuals as a result of the decisive efforts that employers have taken which has led to the elimination of the double-digit health care costs increases that just a few years ago many considered an incurable, permanent feature of our health system.

We urge you to move forward on future incremental health reforms by recognizing that the private, voluntary sponsorship of health care benefits has been both a foundation of health coverage for most Americans and an important agent for change. Benefit mandates, antimanaged care legislation and increased regulatory burdens erode that foundation by raising the cost of health benefits, leading some employers—especially smaller and medium sized firms—to discontinue coverage and causing more employees to opt out of health coverage when asked to contribute to higher premiums. We urge you to reject those measures that only add to health care costs or increase the burdens on employers who sponsor health benefits. Employer sponsors of health benefit plans can and should be important allies in the continuing efforts to reshape the health care marketplace and we urge that you take steps to strengthen that alliance as you consider the next steps down the road of incremental health reform.

IMPLEMENTATION ISSUES RELATED TO HIPAA

Much hard work remains if the Health Insurance Portability and Accountability Act (HIPAA) is to stand the test of time. This work has already begun in the three federal agencies which are charged with developing a single set of guidance and regulations on HIPAA by April 1, 1997, but that, too, is only a beginning. The ultimate test of the legislation lies ahead in the ability of employers, health plans and plan participants to understand the provisions of the Act and easily apply them on a daily basis.

Our comments on implementation concerns related to the health insurance portability act are based on the work of an APPWP task force which has been reviewing the Act since its enactment. In addition to these comments, we have identified several other more minor and technical concerns with the legislation which we have shared with the agencies responsible for issuing regulations and guidance on the statute.

1. Certification issues

A basic requirement of HIPAA is that an individual's prior health coverage be certified by either the employer who sponsored the health benefits or by the health plan itself. Much now depends on how this basic requirement is implemented and whether employers and health plans will be able to meet the expectations and timetables set out in the Act.

In most cases, the certification of the prior coverage of an employee should be quite straight forward. However, the ability to certify the period of coverage of the employee's spouse and other dependents who are covered under the same plan can be much more problematic. Many health plans and employers simply do not have accurate records that track the exact time periods of enrollment for every individual who is eligible under a family coverage plan. Children, for example, may drop off a health plan at different times as they move to be covered under a spouse's plan or go off to school. Spouses may drop off the employee's health plan due to changes in family circumstances that the employer is not aware of or because the spouse has elected coverage through another employer's plan. In some cases, employers will have knowledge about these changes, but frequently they do not. These sorts of circumstances will make it nearly impossible for either the employer or the health plan to comply with the requirement that all individuals be certified for the period of their prior coverage.

We believe that there may be ways to address the practical difficulties that employers and health plans will soon face as they attempt to provide individual health coverage certificates. As a starting point, we believe that the regulations implementing the Act should make a distinction between certificates of prior coverage which must be provided to employees and those provided to a spouse or the dependents of an employee. Under the Act, in most cases the issuance of certificates will begin on January 1, 1998. This date may provide sufficient lead time for many employers to issue coverage certificates to employees, but we believe that a transition period needs to be established for the certificates to be provided to spouses and dependents.

During the transition period, we recommend that an alternative procedure be available to establish the prior coverage period of a spouse or dependent in those cases where the period cannot be established by enrollment records maintained by an employer or health plan. In these instances, we recommend that a certificate be issued based on an individual's attestation of the period during which a spouse or dependent was covered under the plan. Because these certificates would be issued based on personal statements and not plan records, the individual attestation should be accompanied by a warning concerning the penalties or sanctions associated with giving false information. We also suggest that employers and health plans be allowed to obtain reasonable documentation to support a certificate based on such personal assertions of prior coverage (such as premium payment documents, claims statements or copies of an insurance policy) before the individual's new health care coverage would become effective, usually at the point that the individual begins a new job.

We recommend that the transition period be in place at least through January 1, 1999, although the exact date should be established in consultation with employers and health plans based on a realistic assessment of the amount of time that will be needed to routinely obtain records on the coverage periods of every individual who is covered under a plan.

We would caution that the whole area of compliance problems associated with the certification procedures of HIPAA is becoming a subject of growing concern for employers and health plans as we approach the effective dates of the Act. It will be very important that the regulations on HIPAA be issued no later than the April 1, 1997 date required by the Act and that the regulations include a flexible approach to compliance which recognizes the practical problems that employers and health plans face today in their ability to produce reliable information on every individual who may have been enrolled in a plan in the Past. Even with the April 1, 1997 issuance of regulations, very little time is available for the regulatory guidance to be translated by employers and for the necessary changes to be made in their operations and procedures and a similar flexible approach for compliance may be needed by some employers even to certify the prior coverage of their direct employees.

We have one final note of caution on the certification procedures. We believe that our recommendations can be accomplished within the existing authority of the implementing agencies and by the April 1 regulatory deadline set in the Act. However, further action by this Committee may be required to postpone the effective dates of the Act if the regulations are delayed or if flexible mechanisms are not established to minimize the expected compliance burdens which we have identified during our review.

2. Preemption of conflicting state laws

In drafting HIPAA, much effort went into defining the federal and State responsibilities. In general, HIPAA builds on the legislative framework of ERISA which was enacted in 1974 and for more than twenty years has established federal standards for employer sponsored group health plans while leaving States their tradi-

tional authority to continue regulating insured health plans for those matters that relate to the business of insurance.

It is clear that the provisions of HIPAA apply to group health plans whether they are insured or self funded. HIPAA also includes an important provision that reinforces the primacy of the federal standards and limits future State actions, except in narrowly prescribed areas such as a State law that might shorten the maximum pre-existing exclusion period for health coverage offered by an insurance carrier which is subject to State regulation.

While issues related to federal preemption are the subject of frequent litigation and are often subject to differing interpretations depending on the facts of a particular case, we continue to strongly support the continuation of the preemption framework established by ERISA and continued under the health insurance portability act. Few issues are more important to employer sponsors of health plans than possible changes in the ERISA preemption structure, especially for employers who operate on a national or multi-state basis. We would encourage regulatory guidance in this area of the portability act to reinforce and clarify the uniformity and primacy of the new federal requirements and the limited scope available for further State actions.

On a related issue, as a logical extension of the preemption provisions of the new portability law, we recommend that employers and health plans be allowed to rely on a uniform written notice to employees to inform them of their rights and responsibilities under HIPAA and a uniform certification form for prior health coverage that would not vary from State to State or among different employers. Variation in the information obtained on previous health coverage for different State purposes or by different employers would significantly complicate the job already facing employer sponsors of health plans. For that reason, we urge as much uniformity as possible in the information provided to employees on the provisions of the Act and on the certification forms which they are required to provide.

3. State opt-out of HIPAA

State and local government plans are permitted to opt out of the requirements of HIPAA. This provision could also result in several practical problems. For example, when changing jobs, State employees and their dependents may not have the documentation to certify their prior health coverage as other individuals will who have had health coverage through private employer sponsored plans. It is also not clear to us whether the opt-out applies if the State or local government contracts with an insurance carrier, as many do, to provide insurance coverage to its employees since the opt-out privilege is not directly extended to carriers. In any event, we believe that the State opt-out requirements need to be clarified and that employers who hire former State or local workers or their dependents who had previous coverage under a government health plan should be allowed to verify claims of prior continuous coverage. It may also be helpful to allow individuals who had previous coverage under a State plan to request a certification of continuous coverage, even if States are not routinely required to provide them.

4. Fraud and abuse provisions

While we support efforts to combat fraud and abuse in all areas of the health care system, we are concerned that the criminal liability language of the Act is very broad and will leave many doubts about whether particular practices might lead to unwarranted litigation. For example, it is not clear how far the chain of liability might extend if a benefits manager, an outside consultant to a health plan or a third parry administrator is aware that an ineligible individual is receiving benefits under the plan. Other ambiguities include the reference in the Act to the ability of law enforcement officials to provide "limited immunity" to individuals during a fraud investigation. In this case, it is simply not clear how the concept of limited immunity would work in practice and the situations to which it might apply. Similarly, we have questions about whether there will be standards or guidance for fraud monitoring efforts that will limit an employer sponsor's vulnerability to fraud as well as its liability under the new criminal sanction provisions.

We recognize that many of these issues are fact sensitive and that law enforcement officials will need to be prudent in their pursuit of health fraud under these new authorities, but we also recommend that further guidance and examples of safe harbor need to be developed to inform plan sponsors and others on how these untested provisios of the law may be applied in the future.

CONCLUSION

We appreciate the opportunity to testify before you today on the Health Insurance Portability and Accountability Act and we welcome the opportunity to work with

this Committee and the three federal agencies charged with implementing the Act. We also look forward to working with the Committee as you consider the steps you may take next to achieve further health care reform.

STATEMENT OF WILLIAM C. SUMMERS

The Professional Insurance Marketing Association (PIMA) is a national association of leading third-party administrators and insurance companies active in marketing all lines of insurance through affinity groups, associations, multiple employer groups, employers, unions, and sponsored programs. PIMA was formed in 1975 to protect the interests of consumers and advance the professional quality of the independent mass-marketers in the insurance profession. PIMA members work together to provide association members and employees of multiple employer groups quality insurance products at a competitive price.

While we have concerns with some of the provisions such as community rating and prohibitions on experience rating, I would like to focus on the definition of Association.

The definition of "professional association" contained in the NAIC Models has 10 criteria that must be met prior to an association being able to offer a plan in the group marketplace. Criteria number one requires that an association must "serve a single profession that requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession." While the definition may allow legislators and regulators great latitude in defining occupations included in the definition of "professional association," it still precludes business associations, agricultural associations, religious organizations, alumni groups, fraternal and civic organizations from offering plans in the group marketplace.

Further, criteria number seven requires that an association have 1,000 members if it is a national association; 500 members if it is a state association; or 200 members if it is a local association. This restriction may preclude bona fide small associations from offering plans.

These positions appear to be counter to the prevailing view that voluntary purchasing groups are one method of resolving the problem of accessibility to, and the affordability of, quality health care coverage. Individuals and small businesses must continue to be allowed to voluntarily band together into large economically powerful purchasing groups to negotiate for a competitive price for a health benefit package. These purchasing groups should be market driven and free from unnecessary governmental restrictions and, where existing groups such as unions, associations, and other types of groupings meet selected criteria, they should be allowed to continue their function of providing health benefits.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that health insurance issuers need not be considered as issuing coverage in the small group market if the coverage is made available in the small group market only through one or more bona fide association.

The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

This language contained in HIPAA allows all bona fide associations to offer coverage. It provides a safeguard against the creation of "sham" associations, while allowing all bona fide associations to offer coverage without occupational or size restrictions.

Further, the Federal statutory provisions pertaining to health insurance issuers in the individual market generally do not preempt State regulation of individual insurance. Nevertheless, if the State standards and requirements prevent the applica-

tion of a Federal requirement, the statute preempts the State standards and requirements and the Federal requirements prevail.

Accordingly, the State standards and requirements must insure at a minimum that every eligible individual in the State is provided access to coverage that comports with Federal requirements. The State standards may not depart from the Federal requirements in a way that diminishes this minimum coverage. The State, however, is permitted to adopt standards that expand the number of individuals who are protected. However, the language contained in the NAIC Models may preclude associations from offering a health plan and may reduce, rather than expand, the number of individuals that are protected.

In addition, we have heard that HCFA may be considering adopting regulations that would further restrict associations in the same manner the NAIC Model Acts have. If this were the case it would further limit the states flexibility that was afforded to them under HIPAA.

For over fifty-five years, association health plans and other voluntary pooling arrangements have served as viable mechanisms for pooling risks along functional lines, affinity ties, and industry lines. These time-honored and workable groups have increased the buying power and market leverage of individuals and small businesses as consumers of health care services. These plans have enabled millions of citizens to have access to quality, affordable health care which was often denied to them through the available market. Today, thousands of unions, associations, and other types of similar groupings provide health coverage benefit programs to millions of employees and their families.

On behalf of the PIMA membership and the associations they administer health insurance for, we would ask the Committee to help preserve strong association language and help insure that neither the NAIC nor HCFA be allowed to impose restrictive language upon states. This will allow associations to continue to be a viable market place for Americans to receive their health insurance benefits.

Thank you for your time and consideration.

Statement of Donald G. Dressler

My name is Don Dressler, and I am President of Insurance Services for Western Growers Association, headquartered in Newport Beach, California. I am submitting this statement for the record on behalf of The Association Healthcare Coalition (TAHC), of which I am immediate past president and current chairman of the legislative committee. TAHC is a nationwide coalition of over 75 trade and professional associations formed for the purpose of maintaining and improving the ability of associations to provide health care benefits to their members.

TAHC greatly appreciates the opportunity to submit a written statement with regard to the Health Insurance Portability & Accountability Act, approved by Congress in 1996.

THE ROLE OF ASSOCIATIONS IN HEALTH CARE

First, it is important to emphasize that bona fide trade and professional associations are a vital source of health care coverage for American workers. A comprehensive survey conducted by W. F. Morneau & Associates found that 779 of 6,300 associations which sponsored employee group health plans reported premiums of $6.2 billion in 1991. This amount is larger than that of the total annual health care premiums of Prudential, the largest health insurance carrier in the nation, in the same year. Moreover, associations have been sponsoring health plans for over 50 years. These are just a few facts which help illustrate how important associations are to our nation's health care delivery system.

Associations are especially vital to enabling small businesses to provide affordable health coverage to their workers, especially in rural areas of the nation. Associations are able to purchase affordable health coverage for pools of small employers because they offer health plans which are specifically designed to meet the health and financial needs of their membership. TAHC's membership is composed of trade and professional associations organized for purposes other than selling insurance. We are not talking here about affinity groups or businesses that simply come together to purchase insurance.

Associations offer a wide variety of approved health plans and managed care arrangements, both fully insured and self-insured, including Blue Cross, Blue Shield, HMO, and PPO plans. The key for associations and the small businesses they serve is retaining the ability to design plans that meet the needs of their members, yet also remain affordable.

As the Committee members consider health reform issues in the 105th Congress, TAHC asks that you recognize the substantial contribution that associations make

to providing health care to millions of American workers. TAHC also urges that any policy changes enacted allow associations to continue providing high quality, yet affordable, health benefits to their members.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

On behalf of TAHC, I want to commend Chairman Jeffords and the other Members of the Committee for their work in the last Congress to provide portability in health insurance coverage. This law provides portability reforms which will make it easier for millions of Americans to maintain their health insurance during times of transition between different sources of employment. Most importantly, the new law will greatly improve the lives of those who have preexisting conditions.

The portability law is especially helpful to agricultural employers and workers like those served by Western Growers Association. Agricultural work is often highly seasonal, thus requiring some workers to move among different employers and regions. The new portability reforms will provide many agricultural workers with the opportunity to seek new employment without jeopardizing their health benefits. Moreover, our health plan at Western Growers Association has provided 90 days of portability to workers for many years, and the new law now provides a more even playing field by requiring that our competitors also provide portability.

The new law also provides an incentive for workers to seek and maintain health coverage, and deters them from waiting to seek coverage until they actually develop some type of medical problem. Thus, these reforms ultimately are beneficial to both workers and small employers in keeping costs down.

While generally viewing HIPAA favorably, the association community does have several concerns about the law and how it is being implemented.

The major difficulty that we have is the inconsistency in state portability standards. It may be difficult for all states to reconcile their small group underwriting laws in time for implementation of HIPAA in July of this year. The association community would prefer a policy of federal preemption of state rules in this area, so that associations which operate across state lines have a common standard with which to comply.

For example, many of the agricultural employers who sponsor health plans for their employees through Western Growers Association operate in a number of states, including California, Arizona, Oregon, Texas, Colorado and Florida. It would be much more efficient for an employer operating in two or more of these states to worry about complying with one set of portability regulations, rather than dealing with a number of different regulations.

The association community is very excited about the Medical Savings Account (MSA) provisions in the new law, and again, we want to commend you for your efforts in this regard. We believe that MSA's are especially well-suited for small employers, and that they will ultimately help contain costs and expand opportunities for workers.

However, we do have some concerns about the law with regard to MSAs. First, we believe that the numerical cap on the number of MSA accounts which can be established, and the uncertainty surrounding how it will be enforced, is counter-productive because it hinders flexibility in plan design. While we understand the reasoning behind why the cap was instituted, we believe it will limit opportunities for many small businesses which are seeking to take advantage of the MSA program.

Another problem that we foresee is the requirement that MSA's be designed with policies which combine a maximum deductible with a maximum out-of-pocket expense cap. This is not consistent with traditional health plan designs, even catastrophic plans, and also acts to limit flexibility in plan design.

Finally, the definition of small employer contained in the law is not consistent with that which is commonly used in other federal statutes, such as the Fair Labor Standards Act, and is, in our opinion, artificially narrow. As such, this inconsistency causes a significant degree of confusion among some employers as to whether or not they are eligible for the MSA program.

AFFORDABILITY IN HEALTH CARE

The passage of portability reforms was an essential step in making health coverage more accessible to millions of Americans. However, there is broad agreement that more needs to be done by Congress to address the issue of making health coverage more affordable to American workers.

TAHC believes strongly that Congress must take further incremental steps to make health coverage more affordable for working Americans. In doing so, it should recognize that a great deal of the affordability problem is a small business issue. Since associations are critical to providing small businesses with expanded opportu-

nities to provide health insurance to their workers, the continued viability of association health plans must be an integral component of any future insurance reform efforts.

It is especially critical that action be taken at this time to address the affordability issue. Despite the fact that overall health care inflation has declined dramatically over the past several years, this trend has not been prevalent for most small businesses. Rather, the small business community continues to experience rising health costs. Moreover, there is considerable evidence that health care inflation in general has begun rising again. This will only exacerbate the ability of small businesses to offer affordable health care to their workers if reforms addressing this issue are not enacted.

TAHC strongly supports legislation to increase the affordability of health insurance through the strengthening and expanding of the Employee Retirement Income Security Act. The ERISA approach to affordability is the most market-oriented and least costly of any approach to health insurance reform. legislation to expand ERISA would make health insurance more affordable by giving small businesses the same tools that large corporations have had for the past two decades to combat rising costs. Indeed, the success of ERISA is one of the primary reasons that health care inflation among large corporations has declined in recent years.

A vital part of maintaining the ability of associations to offer affordable health plans in today's market is to allow them to operate as either fully-insured or self-insured ERISA plans. This would allow associations greater flexibility in designing health plans which meet their members' health care needs in the most affordable manner. TAHC strongly supports legislation to accomplish this goal.

Just as vital to the goal of maintaining association health plans is the enactment of reforms to ensure that only bonafide associations may operate in this field. TAHC supports regulation at the federal level for this purpose, including full funding of reserves, adequate disclosure of plan status to participants, along with audits and actuarial certification of financial status.

CONCLUSION

The 104th Congress should be commended for enacting incremental reforms such as portability and limited MSA plans. TAHC urges the 105th Congress to take the next step, which is to enact health insurance reform which provides real affordability. In doing so, Congress must recognize the role that bonafide trade and professional associations play in providing affordability. Further health reform should take a market oriented approach to strengthening the ability of association plans to continue providing health care to the millions of employers and employees which they serve, as they have been doing for over 50 years.

Again, thank you for the opportunity to submit a statement for the hearing record. TAHC looks forward to working with the Committee during the 105th Congress.

AMERICAN BAR ASSOCIATION,
WASHINGTON, DC 20005-1009,
February 14, 1997.

Hon. JAMES M. JEFFORDS,
U.S. Senate,
Washington, DC 20510.

DEAR MR. CHAIRMAN: On February 11, 1997, your Committee held hearings on the Health Insurance Portability and Protection Act of 1996 (HIPPA). In light of the hearings, the ABA would like to bring to your attention our concern about Section 217 of the Act, which contains a provision that criminalizes certain asset transfers made for the purpose of qualifying for Medicaid benefits. Upon recommendation of the state bars of Ohio and New York, on February 3, 1997, the ABA House of Delegates adopted the enclosed resolution urging repeal of that provision.

No one questions the importance of doing everything possible to eradicate fraud and abuse from the Medicaid program. However, Section 217 does nothing to further that goal. Instead, it serves only to instill needless anxiety and fear in the minds of the majority of senior citizens who try to plan responsibly for their old age and long-term care needs. In addition, viewed solely from the perspective of criminal law, the provision contains serious Constitutional flaws. Many members of Congress and aging groups were surprised that Section 217 was included in the final version of HIPPA. But whether there by accident or design, Section 217 should be removed. Enclosed, for your information, is a background report considered by the House of Delegates when it adopted policy for the ABA. The report, while not ABA policy, discusses in detail the multiple defects of Section 217.

We respectfully request that this letter, along with the enclosures, be included in the record of the hearings.

Sincerely,

ROBERT D. EVANS,

ADOPTED BY THE ABA HOUSE OF DELEGATES—FEBRUARY 3, 1997

RESOLUTION

RESOLVED, That the American Bar Association urges the repeal of Section 217 of the Health Insurance Portability and Accountability Act of 1996, effective January 1, 1997, which criminalizes certain asset transfers for the purpose of qualifying for Medicaid benefits.

OHIO STATE BAR ASSOCIATION REPORT

42 U.S.C. §1320a-7b enumerates several fraudulent actions involving Medicare and Medicaid that are subject to criminal penalties upon conviction. This section was amended by §217 of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (H.R. 3103), signed into law by President Clinton on August 21, 1996, effective January 1, 1997. The amendment criminalizes certain transfers of assets made in order to become eligible for Medicaid. The language of 42 U.S.C. §1320a-7b, as amended by §217, is attached as Appendix A. This policy recommendation urges repeal of §217.

The aim of §217 is to discourage and punish certain transfers of property that are perceived as abusive manipulations of the Medicaid eligibility rules. Apart from the language of the amendment itself, there is virtually no legislative history to this language—no hearing, no report, no comments on the floor, nor other record amplifying the meaning of the language. Ascertaining Congressional intent in any helpful way is difficult, if not impossible.

In addition to the uncertainty of Congressional intent, the literal meaning of the provision itself is plagued with vagaries and defects that make it difficult to decipher, more difficult to apply, possibly unconstitutional,[1] and harmful to innocent senior citizens. At least four significant problems have been identified:

1. It is impossible to know for sure whether a particular disposition of assets is a crime until some time after the transaction is completed and only after someone else (a Medicaid official) makes a determination that triggers a period of ineligibility. There is virtually no precedent for this kind of after-the-fact attachment of criminal liability, except perhaps the situation where an assault victim dies some time after the assault and the defendant is later charged with murder. However, the analogy is less than convincing since the perpetrator of an assault knows quite well at the time of the incident that the act is criminal—only the degree is in doubt.

Since the individual is unable to assess whether his or her act is criminal at the time it is completed, the provision is vulnerable to constitutional challenge as an unduly vague criminal statute. The only interpretation of the statute that would arguably cure this defect is to read the qualifying language which now states "if disposing of assets results in the imposition of a period of ineligibility" as meaning "if disposing of assets could possibly result in the imposition of a period of ineligibility." However, if Congress had meant this, it is generally presumed that they would have plainly said it.

2. The provision affects only applicants who are already penalized under the law, and does little to deter those few individuals most able to consider "gaming" the Medicaid system. As noted above, the language targets only a disposal of assets "that results in the imposition of a period of ineligibility" from Medicaid. The phrase alludes to the Medicaid rules that, with some exceptions, disqualify from coverage anyone who is entering or residing in a nursing home who has given away property for less than fair market value within 36 months of application (the "lookback period"). The length of the disqualification period depends on how much property has been given away. But, in order to face disqualification, one must apply for benefits, the offending transfer must have been made known, and the period of disqualification (which is measured from the date of transfer) must still be running at the time of application. It is difficult to find any rationale for criminally penalizing these individuals, since these are the ones who arguably have played by the rules, in that

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[1] See also, National Academy of Elder Law Attorneys, NAELA Legislative Alert and Update—Part I: H.R. 3103, The Health Insurance Portability and Accountability Act of 1996, August 28, 1996.

they have disclosed their transfers and accepted the administrative penalty of disqualification from Medicaid.

As a practical matter, no potential Medicaid applicant with correct information and advice about the law would apply for benefits during the period this sanction applies. Those with good advice would wait out the 36 month lookback period before applying in order to avoid imposition of a period of ineligibility. In effect, only the "honest but ignorant" are likely to fall into this criminal net. Advocates for the poor argue that the group most vulnerable to this provision is likely to be lower income persons and families who lack the financial ability to pay for legal advice. The demographics suggest that this vulnerable group consists largely of frail, older women of modest means. A writer in the National Journal summed up the flawed aim of the act by the title of an editorial, "Let's Throw Grandma In Jail."[2]

3. Section 217 makes criminals out of many persons who in good faith transfer assets for legitimate purposes. Gifts to grandchildren to help pay for their education, for example, could become disqualifying transfers if the older person suddenly suffered an illness requiring nursing home care. If the donor knew that such gifts could affect Medicaid eligibility, then he or she could face possible criminal sanction (although the required "mens rea" of the criminal act, discussed further below, is somewhat unclear).

The provision also criminalizes a transfer in one set of circumstances but permits an identical transfer in a different set of circumstances. For example, if Mr. Smith transfers assets impermissibly but is able to wait 36 months before applying for Medicaid, no period of Medicaid ineligibility will be imposed and, hence, no crime will have occurred.

However, if Mr. Smith had made the exact same transfer but failed to or been unable to wait out the 36 months, not only would a period of Medicaid ineligibility be imposed but Mr. Smith would also be subject to criminal prosecution. The people most likely to be caught in the criminal trap created by §217 are those people without the funds to either obtain legal advice or to wait out the 36 months. The individuals most likely to escape §217 are the very individuals with the funds to pay for lawyers and long-term care that §217 was intended to deter from making improper transfers.

4. The mens rea of the statute is "knowingly and willingly." However, it is not clear what it is that must be knowing and willing.

> Is it merely disposing of assets that must be knowing and willing? If this is all that is required, then the provision creates strict liability—an unlikely construction of a criminal provision.
>
> Must the aim of becoming eligible for medical assistance also be knowing and willing? This perhaps is the most likely construction, although it is unclear how mixed intentions would be treated under this language. That is, if the individual has another perfectly legitimate motive—such as helping a grandchild through college—along with the aim of becoming Medicaid eligible, is criminal liability still triggered?
>
> Must an individual also know and intend that a period of ineligibility will result from the disposition of assets? If yes, then the provision requires a fairly sophisticated knowledge of Medicaid to be criminally liable under this act. But if no, then the provision traps only uninformed or misinformed applicants.

Must the individual also know that the disposition is against the law? Recently, the U.S. Supreme Court, in Ratzlaf v. United States, 114 S. Ct. 655 (1994), interpreted the wilfulness requirement in a federal criminal law prohibiting the structuring of certain banking transactions for purposes of avoiding reporting requirements to require not only knowledge of the reporting requirement but also knowledge that the strategy for avoiding the reporting requirement was actually unlawful.[3] The Court reasoned that "currency structuring is not inevitably nefarious." Nor is it "invariably motivated by a desire to keep the Government in the dark."[4] In other words, there are other legitimate reasons why an individual might wish to avoid reporting requirements. This interpretation of wilfulness is equally applicable to §217 as well. Under this interpretation, a necessary element of the crime is that the indi-

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[2] Marilyn Werber Serafini, "Let's Throw Grandma In Jail," National Journal 1922 (September 7, 1996).

[3] Ratzlaf involved a federal law requiring domestic banks to report cash transactions over $10,000 to the Secretary of the Treasury [31 U.S.C. §5313(a)]. Under this law, it is illegal to "structure" a transaction, i.e., to break up a single transaction above $10,000 into two or more separate transaction for purposes of evading the reporting requirement [31 U.S.C. §5324(3)].

[4] 114 S.Ct. at 660, 661.

vidual actually knew that the disposition of the assets was criminal, thus making it particularly difficult to prosecute any alleged offender under §217.

Since the language of §217 is riddled with uncertainty. At a minimum, it would require substantial clarification via technical amendments to make it intelligible. But even with clarifying amendments, it would remain rightfully subject to criticism as an improper use of criminal law to solve a poorly understood public policy problem, i.e., abusive Medicaid planning. Moreover, it is a problem that has not been shown to be very widespread or significant in budgetary impact.[5]

The timing and lack of debate on the amendment is also unfortunate. Congress significantly tightened Medicaid eligibility rules and narrowed many of the loopholes in Medicaid in 1993.[6] If the 1993 changes have been inadequate, policy makers should expect to have some empirical basis for the conclusion. Congress has convened no hearings nor or taken other initiative to identify continuing problems since 1993. If there is indeed a continuing problem with abuse of the Medicaid system by applicants, then hearings, study, and full debate should be advocated.

Even if one concludes that abusive Medicaid planning is indeed a significant problem, the tacking on of a criminal penalty to an already existent civil penalty serves no material purpose in remedying anything. If the provision ultimately targets the wrong people, penalizes transactions already penalized, and is largely unintelligible on its face, then it will likely do nothing other than scare off potential Medicaid applicants who lack good information but who possess a legitimate need for Medicaid.[7] Those with the intent and resources to "game" the system fraudulently will still be able to do so. If a problem does exist, the more direct remedy is to tighten remaining eligibility loopholes; or better yet, fundamentally restructure access to and payment for long-term care. The more fundamental challenge is to make long-term care services available to all persons who need it on an equitable and affordable basis.

Finally, §217 also has an impact upon lawyers who advise potential Medicaid applicants. Lawyers and other advisors may be liable under §217 by virtue of aiding, abetting, or counseling individuals who break the law.[8] The provision is intended to chill the practice of counseling others in Medicaid planning. Yet, the likely impact of the provision is to increase the demand for advice on Medicaid planning, since the risks in carrying out any property transactions are higher by virtue of criminal sanctions. Section 217 creates more work for lawyers, not less; but it is work that should not be necessary. Individuals should not be intimidated into seeing a lawyer because of vaguely targeted criminal sanctions on behavior that falls within the normal scope of estate planning.

Need for ABA Action

The flaws and problems described above have generally led consumer-oriented and legal groups to call for the repeal of §217, some openly and others behind the scenes. As of this writing, the American Association of Retired Persons, the Alzheimer's Association, the Leadership Council on Aging (a group of some 42 national organizations in the field of aging), the National Academy of Elder Law Attorneys, and a number of state bar associations have adopted policies seeking repeal of §217. The American Bar Association, as the national representative of the legal profession, serves an important national purpose in promoting improvements in the justice system, meaningful access to legal representation, and improvements in the law that serve the changing needs of society, and understanding of and respect for the law (Association Goals I through IV). Because §217 causes needless worry and anxiety for many senior citizens, inappropriately uses the criminal justice system to solve a heath and long-term care policy problem, and does so without adequate information or debate, it is appropriate for the ABA to speak out strongly in favor of its repeal.

As of early January 1997, one bill—H.R.216—has been introduced in the U.S. Congress, by Congressman Steven C. LaTourette (R-OH) on January 6, 1997. The sole function of H.R. 216 is to repeal §217. Congressman LaTourette has requested that the Speaker place this bill on the "corrections day" calendar so that the bill

[5] The U.S. General Accounting Office conducted a study of asset divestiture in Massachusetts in 1993. The GAO found that 13% of all applicants in a one month period had transferred some assets without fair value. Of those transfers, nearly 70% of the total value transferred was related to applications that were denied or withdrawn. The finding suggests that the current rules effectively denied Medicaid to most of those individuals who made uncompensated transfers of assets.

[6] The changes were enacted in §13611 of the Omnibus Budget Reconciliation Act of 1993.

[7] Patricia Nemore, Health Reform Bill Criminalizes Gifts to Qualify for Medicaid, Washington, D.C. National Senior Citizens Law Center, August 24, 1996.

[8] Tide 18 U.S.C. §2 imposes criminal liability on anyone who "aides, abets, counsels, commands, induces or procures" the commission of a federal offense by another.

may be considered as a technical amendment to the Health Insurance Portability and Accountability Act. The present recommendation will enable the ABA to support H.R. 216. Similar legislation has not yet been introduced in the Senate (as of 1117/97).

Respectfully submitted,

JOHN B. ROBERTSON,
President.

APPENDIX A

[The language of Section 217 of the Health Insurance Portability & Accountability Act of 1996 is shown in bold type]

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 7—SOCIAL SECURITY, SUBCHAPTER XI—GENERAL PROVISIONS AND PEER REVIEW

PART A—GENERAL PROVISIONS

§1320a-7b. Criminal penalties for acts involving Medicare or State health care programs.

(a) MAKING OR CAUSING TO BE MADE FALSE STATEMENTS OR REPRESENTATIONS

Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting

(A) his initial or continued right to any such benefit or payment, or

(B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, or

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under subchapter XVIII of this chapter or a State health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a state plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),

shall

(I) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or

(ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under subchapter XIX of this chapter is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of that subchapter or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restric-

tion, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

February 14, 1997.

Hon. JIM JEFFORDS,
U.S. Senate,
Washington, DC 20510.

DEAR SENATOR JEFFORDS: On behalf of the organizations listed below we are writing to express our concern with a provision contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. While (HIPAA) was a significant step forward in providing additional health security for many working families, a provision applying to non-federal governmental plans could leave millions of state and local government employees excluded from the most important protections in the new law.

Title XXVII, Sec. 2721 "Exclusion of Certain Plans," permits non-federal governmental plans to elect to be excluded from sub-parts 1 and 2 of the Act. We urge you, under your regulatory authority, to require that non-federal governmental plans notify the U.S. Department of Health and Human Services if they elect to be excluded, and that this notification be required for each plan year that a plan elects to be excluded.

In addition, it is important that if non federal governmental plans elect to be excluded, they describe their plans' policies on pre-existing conditions to the U.S. Department of Health and Human Services along with their notification of exclusion. Without notification of the election to be excluded and description of pre-existing condition policies, it will be impossible to track the number of people covered by the new law and determine its effectiveness.

The regulations should also clearly state that this section does not abrogate any state collective bargaining statute or the obligation of any non-federal government entity to bargain collectively over wages, benefits and working conditions, including any changes to such wages, benefits and working conditions.

Hope you will join us in advocating that this particular provision of the Health Insurance Portability Act be amended in the 105th Congress to make sure the portability protections are extended to employees and dependents covered by nonfederal governmental plans.

We also ask that a copy of our letter be made a part of the committee hearing record of February 11, 1997.

Sincerely,

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES (AFSCME),
NATIONAL EDUCATION ASSOCIATION (NEA),
PUBLIC EMPLOYEE DEPARTMENT, AFL-CIO,
AMERICAN FEDERATION OF TEACHERS (AFT),
SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU).

STATEMENT OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman, on behalf of our member health plans, the American Association of Health Plans (AAHP) would like to commend the Committee for holding this hearing on the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The AAHP is the principal national trade association representing HMOs, PPOs, and other network-based plans. The Association represents approximately 1200 member health plans serving over 120 million Americans, and, importantly, many of our members issue coverage in the small group and individual insurance markets.

We appreciate this opportunity to bring to your attention our experience and concerns in relation to the development of policies to implement this significant law. We recognize that the development of appropriate federal regulations to implement this new law is taking place under a severely restricted time period. To put these policies in place by April 1 requires a very substantial effort on the part of the three federal agencies with responsibility under the law. We want to commend the interdepartmental working group representing the Departments of Health and Human Services, Labor, and Treasury for their willingness to meet with interested parties.

At the outset, we would like to urge this Committee to continue careful oversight of the implementation of this law. There are likely to be issues that arise following the publication of the April 1 regulations that may require farther consultation with the appropriate executive branch agencies. We believe it is critical that the new federal requirements are designed in a manner that can be most easily incorporated

into the existing state regulatory structure for health plans and insurers. Our member plans urge those responsible for developing the implementing regulations to strive for clarity in delineating the federal requirements, including requirements for reporting information related to prior coverage.

In our review of the potential regulatory issues associated with the implementation of HIPAA, we are particularly concerned about the documentation and process required to certify periods of creditable coverage. Under the law, group health plans and issuers of group health plans are required to provide certification of creditable coverage under specified circumstances. In our view the law does not clearly distinguish the responsibilities of the issuer and the employer with respect to the certification obligation. The law does indicate that employers are not required to issue a notice if the issuer provides certification, but there is no comparable waiver for issuers if the employer provides the appropriate notice. Certainly, there is no intent for both parties to provide notices.

In a related matter, we would like to call your attention to the fact that health plans may not have available to them all of the information required to issue a certification of creditable coverage. For example, information on all dependents and spouses, including their dates of enrollment and termination, may not be known to many group plans. Again, it will be important for the regulations to assign the responsibility for this function to the party with access to the necessary data.

We also believe additional clarification is necessary with respect to whether a notice is automatically triggered if one of the specified events occurs or whether the provision of the notice is only required when the affected party—the worker, spouse, or dependent—requests it. AAHP recommends that the regulations clarify this issue with consideration for which avenue will be the best means of promoting the exercise of HIPAA rights while not imposing undue administrative burdens on health plan issuers and employers.

With regard to the information reported in a certification of creditable coverage, health plan issuers should not be responsible for reporting any information concerning coverage periods under other plans or during other periods of employment. The certification should not be the vehicle for providing a cumulative coverage record of the individual. Rather, in cases where there are multiple plans involved, the individual should be responsible for obtaining certification from the appropriate issuer or employer. In addition, we believe it is important for the regulations to make clear the employee's obligation to report any change in dependent or spousal coverage status to his or her employer or, if applicable, to his or her health plan. Finally, in order to facilitate compliance and reduce administrative burdens, the regulations should specify the data elements that must be included in the certification of the period of prior creditable coverage. Employers, employees, issuers, and oversight agencies will benefit from consistency in these data elements.

We believe that federal requirements should also clarify a number of issues related to the use of an alternative method of crediting coverage (i.e., apply pre-existing condition exclusions based on coverage of benefits within each of several classes or categories of benefits). For example, if a health plan issuer elects to use the alternative method, is such a decision permanently binding? Does the election apply to all types of health plans issued by the health plan issuer or can the election be made separately for each type of plan?

Our member plans have also raised questions about what discretion they may be given under the regulations to use alternative methods to verify periods of creditable coverage in the absence of a certificate. To ensure that all members of our plans are treated fairly, we believe the regulations should specify the process to be used, in the absence of a certificate, to verify an individual's prior coverage.

We would like to raise one final issue on behalf of our member plans related to the requirement to renew coverage offered in the individual market to qualified individuals with prior group coverage. The law sets forth a series of exceptions related to failure to pay premiums, fraud, withdrawal of the product from the market, and movement out of the service area. However, the law is silent on whether coverage must be renewable once the individual has attained entitlement to Medicare.

Under the Medicare statute, it is unlawful for an issuer to offer a health plan to Medicare beneficiaries that duplicates coverage that they are otherwise entitled to under the program. Moreover, a number of states have adopted exceptions to guaranteed renewal for individual products to conform to the Medicare requirements. We do not believe it was the intent of Congress to require health plans to offer unnecessary and duplicative coverage to Medicare beneficiaries. However, unless there is some clarification in the regulations or the statute, health plans serving the individual market could be faced with an unresolvable conflict. We recommend that the guaranteed renewable requirement for individual products be suspended—in the

same manner as is the requirement for guaranteed availability—when an individual becomes entitled to Medicare coverage.

In conclusion, Mr. Chairman, we want to thank you for holding this hearing and for the continuing interest by this Committee in the implementation of HIPAA. We want to assure you that we are making every effort to work with the responsible agencies to ensure a smooth transition to the new requirements. We believe it is important that the regulations clearly delineate the federal requirements so that health plans and employers, who have the administrative responsibility for ensuring portability of benefits in a highly mobile workforce, can help meet the goals of the Act.

Statement of Michael R. Losey

Mr. Chairman and Members of the Subcommittee: My name is Michael R. Losey, SPHR, and I am the President and CEO of the Society for Human Resource Management (SHRM). The Society is the leading voice of the human resource profession, representing the interests of 80,000 professional and student members from around the world. SHRM provides its membership with education and information services, conferences and seminars, government and media representation, online services and publications that equip human resource professionals for their roles as leaders and decision makers within their organizations. The Society is a founding member and I am the Secretary General of the World Federation of Personnel Management Associations (WFPMA) which links human resource associations in 55 nations.

Mr. Chairman, I appreciate the opportunity to submit testimony to the Subcommittee today and share my experience, as well as the experience of thousands of human resource managers who constitute the Society for Human Resource Management.

I. PORTABILITY

SHRM Position on Portability

The Society firmly believes that some employees who have an existing health problem remain in jobs in order to maintain their health insurance coverage. Many insurance policies include a "pre-existing condition exclusion" in their health policies for at least the first year of health care[1] coverage. Unable or unwilling to bear the cost of treatment alone, employees with these conditions often feel trapped in their jobs. Reforms should allow individuals to not only move from one employer to another without the fear of losing health care coverage, but also advance mobility in a free enterprise system.

SHRM has accordingly supported portability of coverage and limitations on the use of preexisting condition exclusions. The new rules that impose a twelve-month cap on preexisting condition exclusions and further limit their application to workers who have maintained their health insurance coverage should lead some employees to be freed from the "job lock" that they may otherwise experience.

As important as portability is, it becomes even more important that employers be given the sufficient guidance so that the objectives of the HIPAA can be accomplished. As the regulations on the HIPAA are drafted, employers and the human resource professionals that help administer benefit programs must be given compliance instruction, while still allowing the flexibility needed to meet the requirements of the law.

Model Certification

A model certification should be provided for employers. It is important to recognize, however, that employers have different ways of tracking employee benefits. As a result, while a model form may be extremely useful for smaller employers wishing to fill out the form manually, other employers may have a computer-based system. For these employers, flexibility to report the information as it is collected and used by the employer will be essential, given the different data fields, formats, fonts, etc.

[1] In a way, limitations on preexisting conditions shift employer health care responsibilities from the "back end" to the "front end." Since most preexisting condition exclusions apply for one year, workers retain COBRA with their former employer during this "waiting period." From an employer's standpoint, however, they are bearing the risk of former employees who retain COBRA coverage. From an employee relations standpoint, the shift to immediate coverage could actually benefit employers who provide this coverage to their new hires. Cost analysis impact is difficult because although the COBRA cost to the worker of 102 percent of premium is allowable, those with COBRA tend to have a higher percentage of claims costs.

Tracking of Dependents

Employers are generally able to track the coverage of employees. Tracking of dependents, however, is more problematic. Many employers use the Social Security number of the employee as the identification number for making claims. The employer may be unaware of the existence or the length of coverage of dependents of the employee. Government agencies should give employers and insurers guidance for tracking of dependents so that the certification will contain all the information needed by the next employer. In addition, employers need assurance that following the dictates of the HIPAA will not create liability for violation of privacy standards, since some employees may not want their employer to know the Social Security Number of their dependents.

"Certification"

The final regulations should acknowledge that employers are only able to certify to the extent that employees provide accurate information. If an employee reports to work, opts for family coverage, and fails to provide information regarding one of the employee's dependents, then when the employee terminates, the certification provided by the employer may not be complete. Since the error would have been caused by the employee and not the employer, then government agencies should not view this as a problem in the employer's "certification." Reasonable effort, rather than total accuracy must be the standard for providing certification.

Definition of Categories of Coverage for Rules on Preexisting Conditions

The Health Insurance Portability and Accountability Act contains two methods of crediting previous coverage. A successor employer may either reduce the plan's preexisting condition exclusion by the aggregate amount of previous coverage that the employee has had [under Section 701 (3)(A)], or reduce the exclusion by the previous categories of coverage that the employee had [Under Section 701 (3)(B)]. Although many employers will not use the secondary method of crediting coverage due to the administrative burden, in order for this secondary method to work at all, it is necessary that agencies first define the categories of coverage.

In addition, the agencies should consider creating one form that would be used by successor employers in inquiring about the previous coverage that an employee has had. Otherwise, the previous employer could receive hundreds of letters from successor employers, each in a different format, each requesting different types of information.

Likewise, previous employers should be able to respond to requests for information using one standard or model form. Once the agencies define what the categories of coverage are, employers should be able to check off a form indicating which categories of insurance were provided. In the alternative, a previous employer should be able to meet the request for information by referring the inquiring employer to the schedule of benefits of the employer's summary plan description.

II. NON-DISCRIMINATION RULES

The non-discrimination rules under the HIPAA prohibit employers and health insurance issuers from establishing rules for eligibility to enroll based on health status, claims experience, medical history, etc. [Section 702, Subsection 1]. The regulations must reiterate that this provision applies only to eligibility of enrollment, and does not apply broad nondiscrimination rules to health plans. Recent litigation has suggested that the Americans with Disabilities Act may apply certain nondiscrimination requirements on plans. Although the final disposition of this litigation is uncertain, executive branch agencies should be careful to restate that nondiscrimination in enrollment, but not benefits, is all that the HIPAA requires.[2]

III. MATERIAL REDUCTION IN BENEFITS

Section 707(B) of the HIPAA requires employers to notify beneficiaries and participants within 60 days if there is a material reduction in covered services. Although this requirement may seem straightforward at the outset, the phrase "material reduction" is not defined. Executive branch agencies must give employers guidance on this provision, since any modification or change may be construed by some as a material reduction.

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[2] See Ouida Sue Parker vs. Metropolitan Life Insurance Co., Schering-Plough Corp. and Health Care Products, Case No. 95-5269, Sixth District, U.S. Court of Appeals.

IV. MEDICAL PRIVACY

Concerns for Regulations

Legitimate Use of Medical Records Must be Protected

America's employers voluntarily provide health care benefits to millions of workers. Employers often pay much of the coverage cost, structure plans to provide cost and quality, and ensure the payment of appropriate benefit claims. However, as part of the voluntary payment of benefits, employers must ensure that health care dollars are used appropriately. Personally identifiable health information is legitimately used to prevent fraud, process claims, make medical claims analysis, and comply with other federal laws, e.g., OSHA and FMLA, and state laws such as workers compensation statutes.

New Standards Impose Administrative Burdens on Small and Large Employers

With the increase in health care inflation, employers have worked to streamline processes and curb costs. Additional administrative burdens imposed by the federal government would run counter to employers' efforts, increase costs and discourage employers from offering plans. While employers are already responsible for maintaining an employee's confidential health records; the proof that employers did so and maintaining consent information would multiply, rather than reduce, the administrative burdens on employers.

New Standards Impose Criminal Penalties

Broad and vague language of federal legislation such as "knowing violation" could make well meaning employers subject to severe penalties, including prison terms. Punitive and criminal sanctions should be limited to apply to the most severe violations of the law, where there is an intent to harm.

V. SUMMARY

Overall, SHRM agrees with the emphasis of the law on portability and preexisting condition exclusions. However, SHPM is concerned that the regulations be drafted in such a way as to ensure that human resource professionals are able to comply with the law and have the flexibility to meet the goals of the Act.

STATEMENT OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Chairman Jeffords, the National Federation of Independent Business (NFIB) is pleased to have the opportunity to submit comments concerning the implementation of the Health Insurance Portability and Accountability Act (HIPAA). NFIB is the nation's largest small business advocacy organization representing 600,000 small business owners in all 50 states and the District of Columbia, including 2,635 businesses in the state of Vermont. The typical NFIB member employs five people and grosses $350,000 in annual sales. NFIB's membership mirrors the nation's industry breakdown with a majority of its members in the service and retail sectors.

NFIB supported the passage of the small business insurance market reforms that were contained in HIPAA as important step forward in the effort to improve our nation's health care system. The elimination of the ability of insurers to automatically cancel group health insurance policies should go a long way toward improving the health care security of participants in the health plans of small employers. Equally important is the law's prohibition on exclusions from group policies for individuals with pre-existing conditions once an individual has fulfilled the law's requirements in this regard.

As a next step to improving our nation's health care system, NFIB supports the enactment of legislation to enable employers to form purchasing groups and self insure in order to obtain the purchasing power and administrative savings that large employers have. Currently, it is impossible for small employers to form multi-state purchasing groups because such groups need to comply with each state's insurance laws on solvency, benefit claims, mandates and premium taxes. If small employers could form national or multi-state purchasing groups that operate under a single set of federal rules they could substantially reduce their overhead costs. It is also crucial that these purchasing groups be able to directly negotiate and contract with providers and health plans. Large employers have found that they can receive a substantial savings through the use of these strategies and, therefore, have been able to provide health coverage to the majority of their employees. However, according to the Employee Benefit Research Institute, only 22 percent of workers and their dependents in firms of less than 10 employees have health care coverage. The National Business Coalition on Health estimates that as many as half of those who

are uninsured would be able to obtain health care coverage if legislation to facilitate small employer purchasing groups is enacted.

Although the Administration plans to issue interim final regulations on HIPAA by April 1, NFIB is pleased that the Administration has said it will continue to accept public comments after this date, and is willing to make changes to the regulations or establish additional guidance as is necessary.

We understand the Administration plans to develop a model form for the certification of coverage of workers and their dependents that may be used by employers. This has the potential to greatly minimize the administration of HIPAA provided the model form is user friendly. As the Committee is aware, small employers are particularly sensitive to any additional administrative costs of providing health insurance given that they already pay approximately 30 percent more than larger companies for similar benefits because of higher administrative costs.

Furthermore, we are aware of the fact that HIPAA is currently ambiguous regarding who will be responsible for the certification of health care coverage, the employer or the insurer. NFIB believes that small employers who are fully insured should not be responsible for such certification.

NFIB also believes it makes sense to ease the transition to compliance with the new law by allowing employers and insurers to use records and evidence submitted by employees regarding the coverage of spouses and dependents, when issuing certification of coverage. Employers and insurers do not currently keep records on periods of enrollment in health plans for spouses and dependents. Without the ability to rely upon the statements and records of employees, it will be impossible for certifications of coverage for spouses and dependents to be issued by the effective date of this bill.

NFIB supported the insurance market reforms contained in HIPAA because we believed it was the next logical step to improving upon our current voluntary system of health care. As the Committee moves forward with additional incremental health care reforms, we caution you against enacting mandatory levels of benefit coverage. An NFIB Education Foundation study has shown that existing state benefit mandates can increase premiums up to 30 percent. Sixteen percent of small businesses owners who do not provide health insurance said they would do so if it were not for costly state benefit mandates. Applying mandates, however well intentioned, will only result in a disincentive for employers to provide coverage for their employees.

Alternatively, NFIB urges the Committee to do all it can to minimize the administrative burdens on small employers. We strongly believe this is best done by enacting legislation to allow legitimate association plans to self insure and form small employer purchasing groups that operate under a single set of federal rules. As the experience of large employers has proven, nothing would do more to promote coverage of those who are currently uninsured. We look forward to working with the you, Mr. Chairman and other members of the 105th Congress in the effort to make this important NFIB legislative priority a reality.

February 3, 1997

By Hand

Health Care Financing Administration
Room 309-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: BPD-886-N

Ladies and Gentlemen:

We are writing to submit the comments of The ERISA Industry Committee (ERIC) regarding implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub.L.104-191).

For the reasons discussed below in specific section-by-section comments, the following concerns represent priorities for ERIC member companies:

- The principal administrative burdens and responsibilities imposed by HIPAA are attributable to the provisions relating to certification of prior coverage. Thus, there is strong consensus that the regulations issued pursuant to HIPAA should provide a safe harbor form for certifying prior coverage.

- Given the significant financial and administrative burden associated with maintaining records for extended periods of time, ERIC members believe an employer should not be required to provide in certifications of prior coverage actual enrollment dates for employees and dependents who have been continuously covered by one or more of the employer's plans for more than 18 months. Since the actual date of enrollment is no longer relevant for any HIPAA purposes once enrollment exceeds 18 months, requiring the inclusion of an actual enrollment date for long-service employees and their dependents is an unnecessary waste of an employer's resources.

- Regulations should also provide several safe-harbor methods of responding to requests for additional information from employers using the alternative method of crediting prior coverage.

- The drafters of HIPAA went to great lengths to circumscribe the provisions of HIPAA and to make clear that the Act was intended to be very limited in scope. This was especially true with respect to the nondiscrimination rules contained in new ERISA §702 (and analogous provisions of the PHSA and IRC). The regulations should emphasize the rules of construction contained in these provisions and expressly reiterate that the extent, scope, nature and duration of specific benefits offered under an employer plan are benefit design decisions that fall entirely outside the purview of the nondiscrimination rules.

- In contrast, the drafters of HIPAA also went to great lengths to make clear that HIPAA's focus is promoting continuity of core health coverage without imposing requirements on the numerous (and often unique) add-on and peripheral benefits made available to employees and their dependents by some (but by no means all) employers. Thus, the regulations should interpret HIPAA's benefit exceptions and exclusions broadly, lest HIPAA discourage employers from offering non-core benefits at all.

ERIC

ERIC is a non-profit association committed to the advancement of the employee retirement, health and welfare benefit plans of America's largest employers. ERIC's members provide comprehensive retirement, health care coverage and other economic security benefits directly to some 25 million active and retired plan participants and beneficiaries. ERIC has a strong interest in proposals affecting its members' ability to deliver those benefits, their cost and effectiveness, and the role of those benefits in the American economy.

Background

These comments are submitted in response to the notice published jointly by the Departments of Health and Human Services, Labor and Treasury in the *Federal Register* on December 30, 1996 (file code BPD-886-N).

Comments

1. General Comments

HIPAA was enacted to rationalize certain aspects of health care coverage markets in order to enhance continuity of coverage, not literally to provide portability of coverage (*i.e.*, transferring the same plan/coverage as employees move from employer to employer) as implied by the legislation's short title and headings. A surprisingly large number of employers and employees are still confused by the use of this and related terminology because it overstates the Act's intended effect. Therefore, one of the primary objectives of the regulations should be to correct this misperception.

Even the more realistic goal of continuity of coverage will be frustrated, however, if implementation of the Act is insensitive to real-world constraints on employers' ability to respond to the Act's objectives. ERIC believes that the efficiency of HIPAA's implementation will be directly proportionate to the degree to which regulations focus on the core objectives of the Act and actively promote ease of administration for employers who are seeking to comply with the Act.

For example, HIPAA's time-line for putting in place information systems and auditing procedures for certifying prior coverage is, as a practical matter, too ambitious for many employers; a longer transition period is needed for the marketplace to fully adapt to these new requirements. Thus, a number of the specific comments that follow relate to ways in which regulations might serve the objectives of HIPAA while providing much-need flexibility.

Throughout HIPAA, the term "plan" is used as though there were a single, uniform definition of the term across all relevant statutes (*e.g.*, ERISA and the IRC). For better or worse, this is not the case Thus, how the requirements of HIPAA are applied, and to whom they are applied, may vary depending on which definition is used. For example, the applicable definition might have a bearing on whether former employees (*e.g.*, retirees) are considered employees. In order to reduce confusion, the regulations should be explicit with respect to which definition is being relied upon.

HIPAA does not directly discuss an employer's ability to delegate plan responsibilities to other parties (*e.g.*, third-party administrators). ERIC believes the regulations should expressly recognize such delegation and that broad flexibility regarding administrative arrangements should be permitted.

The entire process of tracking, certifying and disclosing information about prior coverage is problematic in circumstances where one company acquires assets (*e.g.*, a division) from another. Holding acquiring employers responsible for certifying events prior to such acquisitions

could force companies to alter the terms of their negotiated agreements. HIPAA's requirements ought not intrude upon companies' unrelated business decisions. Therefore, ERIC urges that the regulations provide that companies acquiring assets from another company are not liable for certifying events prior to the asset acquisition unless the parties to the transaction have agreed to transfer that responsibility.

2. Specific Section-by-Section Comments

Given the overlap among HIPAA's amendments to ERISA, PHSA and the IRC, the following comments refer only to the relevant ERISA section, but they generally apply to the parallel PHSA and IRC provisions as well.

a. New ERISA §701

***Plan requests for information regarding preexisting conditions*:** The principal difference between the generic definition of "preexisting condition exclusion" [henceforth PCE] in §701(b)(1)(A) and permissible PCEs under §701(a)(1) is that permissible PCEs are limited to conditions where medical advice, diagnosis, care or treatment was actually recommended or received prior to enrollment. Though the structure of the statute as a whole clearly contemplates that participants and beneficiaries may be asked to provide information about such conditions, it does not expressly authorizes such information requests. Thus, ERIC recommends that the appropriateness of such information requests by plans be expressly recognized in the regulations.

***Clarification of the definition of "enrollment date"*:** The definition of "enrollment date" contained in §701(b)(2) is somewhat circular and might not expressly take into account the fact that, as a practical matter, the date on which a participant's medical care expenses first become covered by a plan is not necessarily the date on which the participant is "enrolled" in the plan (within the traditional meaning of the term as used by some plans). For example, a participant who is actually "enrolled" several days after commencing employment might nevertheless be covered as of the first day of employment. To avoid confusion, ERIC urges that the regulations clarify that "enrollment date" is to be interpreted as the effective date of a participant's coverage.

The definition of "enrollment date" appears to indicate that for purposes of crediting coverage, the first day of an employee's waiting period -- not the actual effective date of his or her enrollment -- is to be considered the "enrollment date" for purposes of the statute. Since this strikes some employers as counterintuitive, the regulations should clarify whether an employer crediting prior coverage [henceforth crediting employer] is required by HIPAA to include a waiting period with a prior employer when crediting prior coverage.

Tracking waiting periods will be problematic for both employers certifying prior coverage [henceforth certifying employers] and crediting employers. Few employers -- even those that already maintain information systems to track enrollment dates -- currently track waiting periods. Moreover, waiting periods may change from year to year. In short, the regulations should take into account the fact that most employers are unable to track waiting periods except on a prospective basis.

***Clarification of definition of "waiting period"*:** As written, the definition of "waiting period" in §701(b)(4) does not appear to distinguish between (1) an applicable waiting period when an individual is first eligible to enroll, and (2) the interval between an employee's initial decision to decline enrollment and his/her enrollment during a subsequent "open season" enrollment period. Failure to make this distinction is significant because the "enrollment date" for purposes of HIPAA can be the first day of a waiting period rather than the actual effective date of enrollment.

If "waiting period" includes the period of time an employee (or dependent) must wait until the next open enrollment period (*i.e.*, the term "waiting period" is not limited to an employee's or dependent's first opportunity to enroll), strong incentives for gaming are created. For example, assume a healthy employee who is hired on January 1 declines coverage, knowing that on the following December 1 he/she will have another opportunity to enroll during "open season"; if the period from January 1 to December 1 is considered a waiting period, then PCEs can be applied only to medical conditions arising before January 1.

ERIC recommends that the regulations clarify the definition of "waiting period" to expressly exclude the intervals between "open season" enrollment periods from the definition. Failure to do so would cause significant administrative problems for health plans. Moreover, it would seriously undermine an important policy objective of HIPAA: to preserve the reasonable use of PCEs as an incentive to encourage individuals to enroll in health plans at their earliest opportunity rather than to wait until they become sick to enroll.

Defining classes or categories of benefits for alternative method of crediting coverage: Many ERIC members (especially those who provide comprehensive coverage and do not currently use PCEs) are concerned about the administrative burden that could be placed on certifying employers by crediting employers' election of the alternative method of crediting coverage under §701(c)(3)(B). Thus, ERIC urges that the regulations take affirmative steps to reduce this administrative burden:

- by making clear that, in the absence of regulations defining such classes or categories of benefits, no crediting employer may elect the alternative method of crediting prior coverage and no certifying employer may be required to provide additional information about such classes or categories of benefits to a crediting employer;

- in the event that such classes or categories of benefits are defined by regulation, by limiting such classes or categories to the fewest feasible number and by ensuring that the classes or categories reflect standard industry classifications and categorizations; and

- by permitting certifying employers to include in such certification sufficient information as to preclude any subsequent requests for supplemental information by a crediting employer that has elected to use the alternative method of crediting coverage.

Certification of Prior Coverage: The agencies' December 30 request for comments asked whether a model certification form should be included in anticipated regulations. ERIC strongly believes that a safe harbor form *should* be provided so that certifying employers have the option to use a pre-approved format for certification while retaining the freedom to use their own format if they choose.

A literal reading of HIPAA suggests that employers must certify a specific enrollment date for long-service employees and their dependents even though the length of their coverage far exceeds any relevant period under the Act. The longer an employee or dependent is covered, the more difficult and expensive it will be for employers to certify the commencement of their coverage. Under these circumstances, insisting on certification of the actual date coverage commenced will result in an unnecessary and unjustifiable waste of resources. ERIC urges that the regulations relieve employers of the need to certify the actual date of enrollment for employees and dependents with continuous coverage exceeding 18 months.

A literal reading of HIPAA also suggests that in many instances employers may be required to issue multiple certifications where one would be adequate. For example, HIPAA could be read as requiring the issuance of a separate certification to each family member rather than a combined certification for the employee and all his/her dependents. ERIC recommends that anticipated regulations permit employers to issue combined certifications in these and similar circumstances.

In addition, concerns have been raised that HIPAA might be read as requiring certifications in numerous situations where continuous coverage is, in fact, maintained. ERIC believes that many of the situations about which concerns have been raised, such as changes of enrollment options (*e.g.*, from high option to low option, from fee-for-service to HMO, from active status to retiree or disabled status, etc.) fall entirely outside HIPAA's scope and should not trigger certification at all. There are other situations that arguably fall within HIPAA's scope where relief is nevertheless warranted. For example, if HIPAA is read literally, upon termination of employment an individual who elects COBRA continuation coverage apparently must receive a certification even though continuity of coverage is maintained and another certification ultimately will be issued when COBRA coverage ends. Therefore, ERIC urges that the regulations acknowledge that enrollment option changes are outside the scope of HIPAA's certification requirements, and that they provide relief from the certification requirement in instances where continuity of coverage is maintained.

As already explained, it is not currently possible in many circumstances for plans to comply with the requirements of §701(e)(1). For example, in the past many plans (especially fee-for-service plans) have not tracked enrollment of dependents until a claim is filed. The dependents of an employee with family coverage may be covered even though the plan has no knowledge of the existence of dependents who did not file claims before coverage ceased. Obviously, a plan cannot certify the coverage of persons it does not know exist, and the regulations should provide relief for plans (at least during an adequate transition period) so they are not held liable for failure to certify coverage for dependents of whom they were unaware. One way -- though not the only way -- to provide such relief is to deem the period for which an employee is certified to have had family coverage to be the period of creditable coverage for all his/her dependents regardless of whether the dependents were ever formally enrolled in the plan.

The phrase "at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation coverage provision," which appears in §701(e)(1)(B), raises many practical difficulties. In the real word, plans do not always receive timely notice of termination of employment; in cases where, under the terms of the plan, coverage ceases before the plan is in fact notified of the change in circumstance, it is impossible for the plan to provide certification "at the time the individual ceases to be covered." Even in cases where plans receive notice before (rather than after) the fact, certifications cannot be generated instantaneously.

Moreover, in the case of qualifying events for purposes of COBRA, the practical obstacles to compliance with the literal requirements of the provision are even greater. For example, given the period of time allowed to employers to notify individuals of their COBRA rights, and the subsequent period of time permitted for eligible individuals to make elections, it may be months before a plan knows conclusively whether an individual is covered during the interim period or not. Therefore, ERIC recommends that the regulations provide a reasonable period of time from the date the plan is informed of a termination of employment and an employee's decision not to elect COBRA continuation coverage to prepare the required certification.

***Disclosure of Prior Coverage*:** ERIC members are concerned about being overwhelmed by requests from crediting employer plans to certify prior coverage on a class-by-class- or category-by-category-of-benefits basis as required under §701(e)(2). In the case of a large employer offering employees a choice among multiple health plans, with thousands of employees entering and leaving employment during the course of a year, having to respond to requests for supplemental information by successor plans on a individual basis will be very burdensome.

The drafters of the provision appear to have intended that both the financial and administrative burden of the alternative method be borne by crediting employers. Therefore, ERIC urges that the regulations permit certifying employers to utilize, at their option, at least the following safe harbor responses to requests for additional information:

- completion of a safe harbor response form, provided in the regulations, that includes a checklist of the classes or categories of coverage defined by regulation; and

- provision of a copy of relevant excerpts from a summary plan description or plan documents.

The regulations also should provide that once a safe harbor response has been given, the certifying employer has no further obligation to provide additional information to the crediting employer. In addition, certifying employers should be required to provide information about only the most recent coverage the individual in question had enrolled in, rather than each successive coverage the employee (or dependent) had elected.

Finally, ERIC urges that the regulations give certifying employers the option to include in certifications of prior coverage, *at the time such certifications are provided to departing plan participants and beneficiaries*, sufficient information to discharge any further obligation to provide supplemental information to crediting employers on an individual basis. This might be accomplished, for example, by permitting certifying employers to attach to such certification materials that satisfy one of the safe harbor responses described above (*e.g.*, a completed safe harbor response form), along with a statement to the effect that attachment of such materials fully satisfies any obligation to provide supplemental information to crediting employer plans electing the alternative method of crediting coverage.

HIPAA authorizes certifying employers to charge crediting employers using the alternative method a reasonable amount to cover the cost of providing requested additional information. ERIC urges that the regulations permit certifying employers to take their true costs (including, but not limited to, administrative, staff time and copying expenses) into account when setting such fees. In addition, certifying employers should be permitted to charge a higher amount for responses to requests that are not consistent with the safe harbor response form, and to require pre-payment before providing any information.

Special Enrollment Periods: Of the criteria for determining whether an employee or dependent is entitled to a special enrollment period, the one that may cause the most practical difficulty is §701(f)(1)(B) relating to the written statement by the employee or dependent at the time coverage is declined. The provision is not specific about what constitutes adequate notice to employees and dependents regarding the significance of this written statement. ERIC suggests that the regulations articulate an easily administrable safe harbor notification process. The regulations might provide, for example, that health plan enrollment forms may incorporate safe harbor notification language so that the same form could be used both for enrollment and for declining enrollment on the basis of other existing coverage.

In addition, ERIC recommends that the regulations also provide the standards that must be met by notification language drafted by employers. A significant number of employers already require employees to show evidence of other existing coverage before allowing them to decline coverage; these employers should not be forced to rewrite their enrollment materials unnecessarily if their current language meets the objectives of the Act.

A number of questions have been raised asking whether HIPAA requires employers to make special enrollment periods available to dependents, and enroll such dependents, under circumstances where enrollment has not typically been permitted in the past. For example, employers typically do not permit dependents to enroll in a plan unless the employee also enrolls in family coverage (*i.e.*, they do not provide dependent-only coverage). As another example, persons who were not a retiree's dependent on the date the retiree enrolled in retiree coverage typically are not eligible to enroll at a later date. In the first illustration, ERIC believes that unless the employee also enrolls in family coverage during the special enrollment period new ERISA §701(f)(2)(A)(i) is not satisfied and the employer is not required to enroll dependents in dependent-only coverage. ERIC also believes, with respect to the second illustration, that §701(f)(2)(A)(i) is not satisfied and the employer is not required to offer a special enrollment period to persons who become dependents after a retiree's enrollment. The regulations should clarify that in both cases HIPAA does not require enrollment of such persons.

Employers that offer cafeteria plans under §125 of the IRC have expressed uncertainty about the interaction of this provision with tax code rules governing cafeteria plans. In particular, the regulations should identify any events that trigger special enrollment periods under HIPAA but that do not also provide an opportunity to change cafeteria plan elections. If there are any such events, ERIC urges that the regulations identify them.

b. New ERISA §702

***Nondiscrimination with respect to eligibility to enroll*:** The legislative history makes clear that §702(a) was intended to function as an "equal access" rule (*i.e.*, that individuals may not be deemed ineligible to enroll in a health plan solely on the basis of their health status). As the rule of construction in §702(a)(2) reiterates, however, the Act places no requirements (other than restrictions related to the use of PCEs and special enrollment periods contained in new ERISA §701) on the "amount, level, extent, or nature of" benefits made available to individuals once they enroll in a plan. In other words, individuals may not be kept out of health plans on account of their health status, but once in the plan, the Act does not prohibit plans from offering benefits that vary based on factors included in the definition of health status (so long as persons with the same health status factor are treated consistently).

Despite the best efforts of the drafters of this provision to articulate a clear distinction between eligibility to enroll (to which the nondiscrimination rule applies) and benefits offered under the terms of a plan to enrolled participants and beneficiaries (to which the nondiscrimination rule does not apply), the scope and effect of this provision is often misunderstood by persons unfamiliar with benefit plan concepts. Therefore, ERIC urges that the regulations make clear that the nondiscrimination rule addresses eligibility to enroll but not benefits offered to enrollees. This could be accomplished, in part, by providing an open-ended list of illustrative benefit design features (*e.g.*, limitations on covered services; limits on inpatient days and outpatient office visits; lifetime and annual dollar caps; limits on the duration of benefits to a specified number of years; deductibles, copayments, out-of-network surcharges and other forms of cost-sharing; etc.) to help distinguish benefit design from eligibility to enroll.

Many health plans, especially those that do not provide for open enrollment periods after an employee declines coverage at the time he/she is hired, permit late enrollment only if the employee can demonstrate evidence of insurability. Since evidence of insurability is one of the elements of health status expressly mentioned in §702, employers are concerned that they can no longer permit late enrollment in this manner. The drafters of this provision do not appear to have intended to preclude this common business practice. Moreover, the purpose of limiting late enrollment to those who can demonstrate evidence of insurability is to encourage individuals to enroll at their first opportunity rather than to wait until they are sick to enroll. If employers cannot condition late enrollment on evidence of insurability, many will not provide opportunities for late enrollment at all -- a policy result that is clearly contrary to HIPAA's objectives. Therefore, ERIC recommends that regulations expressly authorize the continued use of evidence of insurability in this manner.

Another common practice is the inclusion of so-called "nonconfinement" provisions in plans. These provisions generally provide that if an employee or dependent is hospitalized on the day coverage is supposed to commence, coverage will not in fact begin until the day the employee or dependent is released from the hospital. It does not appear that HIPAA's drafters intended to preclude this practice, which is analogous to a waiting period in that it does not preclude an employee or dependent from enrolling but delays the effective date of the coverage. ERIC urges that the regulations make this clear.

Although §702 was intended to prevent discrimination *against* persons on the basis of health status, it is unclear whether the provision, as written, could be interpreted as prohibiting a plan from treating an individual *more favorably* based on his or her health status. The problem arises because HIPAA prohibits "...rules for eligibility...based on...health status-related factors...." For example, some employers offer a supplemental health plan to employees with specific medical conditions (*e.g.*, post-operative coronary patients) if the employee participates in an after-care

program designed to enhance their recovery; only employees with this specific condition are eligible to enroll in the supplemental plan. Applying the nondiscrimination rule to this type of health status-related eligibility rule could force employers to choose between making the supplemental coverage available to everyone or to no one; the most likely result of imposing such choices on employers is a loss of coverage that is contrary to the policy objectives of the Act. Therefore, ERIC urges that the regulations expressly authorize health status-related eligibility rules where the purpose of the rule is to make supplemental coverage available to individuals with specific health needs.

***Nondiscrimination with respect to premium contributions*:** It is not uncommon for employers (especially the largest employers) to vary plan participants' premiums or contributions on the basis of such non-health status-related factors as the division or subsidiary an employee works in, geographic location, active or retired status, etc. The general rule contained in §702(b)(1) does not appear to preclude these types of variations in premiums or contributions, and the phrase "similarly situated" implicitly reinforces their apparent permissibility. Nevertheless, given the sensitivity of this issue, and the fact that the rule of construction in §702(b)(2) does not provide examples of permissible non-health status-related variations in premiums or contributions, ERIC recommends that the regulations provide a variety of examples.

c. New ERISA §704

***Clarifying the Scope of ERISA Preemption*:** Despite the mutually exclusive definitions of employer, group health plan, health insurance issuer and health insurance coverage contained in new ERISA §706 and elsewhere, many readers of §704 are confused about its effect. Therefore, ERIC urges that the regulations make clear that:

- ERISA's preemption of state laws relating to employee benefit plans is undiminished by the Act; and
- the scope of ERISA's so-called "savings clause" (§514(b)(2)(A)) is effectively narrowed by new ERISA §704 in that the provision extends ERISA preemption to less-protective state laws relating to PCE requirements imposed on entities engaging in the business of insurance.

d. New ERISA §705

***Clarifying the rules relating to excepted benefits*:** There is a certain amount of confusion about the intended operation of §705(b) and (c). To a large extent, this is the result of uncertainty regarding definitions contained in §706 (discussed below). ERIC recommends that examples of each type of excepted benefit (*i.e.*, limited, noncoordinated and supplemental) be provided in the regulations.

e. New ERISA §706

***Clarifying the definition of medical care*:** The redundant use of the phrase "amounts paid for" in §706(a)(2), (2)(B) and (2)(C) raises the question whether the redundancy is meaningful or just a technical error. ERIC believes that the redundancy is a technical error, and recommends that the regulations reflect this understanding.

***Clarifying the definition of limited scope dental or vision benefit*:** It is not clear what constitutes a "limited scope dental or vision benefit" under §706(c)(2)(A). For example, it is unclear whether any dental or vision benefit is considered "limited in scope" simply by virtue of being offered separately, or whether only some separately-offered dental and vision benefits (*e.g.*, benefits that exclude surgery and other dental-related or vision-related "medical" procedures) are considered "limited scope" benefits. Since HIPAA provides no criteria for distinguishing between "limited scope" and "non-limited scope" vision and dental benefits, ERIC urges that the regulations reflect the view that any separately-offered dental or vision benefits be considered "limited in scope."

f. New ERISA §707

***Disclosure of information to participants and beneficiaries*:** §707(c) requires that plan participants and beneficiaries be notified of reductions in coverage within 60 days following adoption of the change. If an employer wishes to enhance the effectiveness of its notice of plan changes by communicating all plan changes at the same time, or by communicating them as part of materials relating to its next "open season," the employer must carefully time the adoption of its plan amendments in order to comply with the notice requirement. Unfortunately, the alternate rule (periodic notice at least every 90 days) does not adequately address this concern. There is no compelling policy reason to force employers to alter their business practices in this manner; thus, ERIC recommends that the regulations provide needed flexibility in the application of this general rule.

§707(c)(1)(B) expressly contemplates disclosure and notification by means other than mail. Employers, as well as participants and beneficiaries, would be well-served by regulations that expressly accommodate electronic media as a permissible means of communicating required information with respect to this provision (and ERISA's reporting and disclosure requirements generally). In particular, employers should be permitted to provide copies of plan amendments and SPDs via company computer networks and the Internet. ERIC recommends that the regulations take a flexible approach. In addition to identifying specific permissible means of electronic communication, the regulations should also establish criteria for determining the permissibility of other modes of communication not enumerated in the regulations. Because communication technology is evolving rapidly, the regulations should be open-ended wherever possible so as not to foreclose use of unforseen modes of communication.

***Effective Dates with Respect to Certification*:** Despite the drafters' intent to provide an adequate transition period in §707(g)(2), there are still likely to be unintended gaps in the certification process for many employers well after the effective dates have passed. Once an employee terminates employment it is often difficult and expensive, if not impossible, for an employer to maintain sufficient contact with a former employee to go back and capture information about a former employee's (or dependent's) coverage. As a practical matter, data that is not captured by an information system in place at the time employment terminates will likely never be captured by the employer.

Due to the length and complexity of HIPAA, a not insignificant number of employers did not become fully aware of their new information collection and certification responsibilities under the Act until some of the relevant effective dates had already passed. Once they did become aware of these new responsibilities, additional lead time was needed to select and implement new information systems. Thus, as a practical matter, the practices described in the §707(g)(2)(C) transition rule for events that occurred prior to June 30, 1996 may be the only reasonable means of certifying coverage for events occurring well after that date. ERIC urges that the regulations extend, under appropriate circumstances, this transitional procedure to events occurring prior to January 1, 1998.

Respectfully submitted,

Mark J. Ugoretz
President

February 10, 1997

The Honorable James M. Jeffords
Chairman, Committee on Labor and Human Resources
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Jeffords:

We are pleased to submit the comments of The ERISA Industry Committee (ERIC) regarding implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub.L.104-191) for the record of the Committee's February 11, 1997 hearing on HIPAA implementation.

Although HIPAA may appear modest in scope to public policy makers, its implementation is anything but simple for the private sector: HIPAA imposes substantial new legal and administrative liabilities on employers and requires them to put in place complex new information systems, all in a very short time frame. The enactment of additional health benefits-related legislation on the heels of HIPAA would be especially disruptive for employers already struggling in good faith to comply with the Act's requirements. Imposing additional requirements risk both widespread noncompliance by employers who can't keep pace as well as a backlash in the form of significant numbers of employers reducing, if not terminating, the health benefits they currently provide to employees, retirees and dependents. Thus, while the focus of the comments that follow relate to HIPAA implementation, the hearing also presents an opportunity for ERIC to urge the Committee to refrain from taking up additional health benefits-related legislation until employers have had time to adjust to the substantial financial and administrative burden imposed by HIPAA and other legislation enacted last year.

ERIC

ERIC is a non-profit association committed to the advancement of the employee retirement, health and welfare benefit plans of America's largest employers. ERIC's members provide comprehensive retirement, health care coverage and other economic security benefits directly to some 25 million active and retired plan participants and beneficiaries. ERIC has a strong interest in proposals affecting its members' ability to deliver those benefits, their cost and effectiveness, and the role of those benefits in the American economy.

Comments

HIPAA was enacted to rationalize certain aspects of health care coverage markets in order to enhance continuity of coverage, not literally to provide portability of coverage[1] as some have inferred from the legislation's short title and headings. A surprisingly large number of employers and employees are still confused by the use of this and related terminology because it overstates the Act's effect. Therefore, one of the challenges of HIPAA implementation is to correct this misperception.

Even the actual (and more realistic) objective of certifying and crediting prior coverage will be frustrated, however, if implementation of the Act is insensitive to real-world constraints on employers' ability to respond to those objectives. ERIC believes that the efficiency of HIPAA's

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[1] *i.e.*, transferring the same plan or coverage as employees move from employer to employer -- a policy option that was rejected as impracticable.

implementation will be directly proportionate to the degree to which regulations focus on the core objectives of the Act and actively promote ease of administration for employers who are seeking to comply with it. For example, HIPAA's time-line for putting in place information systems and auditing procedures for certifying prior coverage is, as a practical matter, too ambitious for many employers, especially with respect to dependent coverage. A longer transition period is needed, and the Committee's oversight of agency activities to implement the Act should stress the need for flexibility in this regard.

Of the detailed comments ERIC submitted to the Departments of Health and Human Services, Labor and Treasury in response to their joint notice published in the *Federal Register* on December 30, 1996, the following issues were consistently among the highest priorities of ERIC member companies:

- The principal administrative burdens and responsibilities imposed by HIPAA are attributable to the provisions relating to certification of prior coverage. Thus, there is strong consensus among ERIC members that the regulations issued pursuant to HIPAA should provide a safe harbor certification form for certifying prior coverage.

- Given the significant financial and administrative burden associated with maintaining records for extended periods of time, ERIC members believe an employer should not be required to provide in certifications of prior coverage actual enrollment dates for employees and dependents who have been continuously covered by one or more of the employer's plans for more than 18 months. Since the actual date of enrollment is no longer relevant for any HIPAA purposes once enrollment exceeds 18 months, requiring the inclusion of an actual enrollment date for long-service employees and their dependents is an unnecessary waste of an employer's resources.

- The regulations should also provide several safe-harbor methods of responding to requests for additional information from employers using the alternative method of crediting prior coverage. Specifically, ERIC urges that employers certifying prior coverage be permitted to utilize, at their option, at least the following safe harbor responses to requests for additional information:

  - completion of a safe harbor response form that includes a checklist of the classes or categories of coverage defined by regulation; and

  - provision of a copy of relevant excerpts from a summary plan description or plan documents.

- The drafters of HIPAA went to great lengths to circumscribe the provisions of the Act, and to make clear the Act was intended to be limited in scope, by including several statutory rules of construction. The regulations should be consistent with and emphasize these rules of construction, and expressly reiterate that the extent, scope, nature and duration of the particular benefits offered under an employer-sponsored plan are benefit design decisions that fall outside the purview of HIPAA.

- HIPAA seeks to promote continuity of core health care coverage without imposing its requirements on the numerous (and often unique) add-on and peripheral benefits made available to employees and their dependents by some (but by no means all) employers. The regulations should interpret HIPAA's benefit exceptions and exclusions broadly, lest the Act discourage employers from offering non-core benefits at all.

Thank you for this opportunity to submit this statement for the hearing record. Attached are the February 3, 1997 comments ERIC submitted in response to the December 30, 1996 joint agency request for comments regarding HIPAA implementation. We would be pleased to provide members of the Committee with additional information concerning our position or comments on the forthcoming regulations, the Act itself, or any other health benefits-related issue. ERIC's Director of Health Policy, Anthony J. Knettel, and I look forward to being of assistance.

Respectfully submitted,

Mark J. Ugoretz
President

[Whereupon, at 12:19 p.m., the committee was adjourned.]

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